# Substance Use Education for Nurses

## SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

University of Pittsburgh
School of Nursing

Prepared 2013 by:

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## Acknowledgements

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We acknowledge in memoriam the contributions of Wayne Shipley, MPA, CAC, LPC, former Director of the Northeast Addiction Technology Transfer Center and SBIRT Clinical Educator for IRETA. Sadly, he passed away on March 5, 2008, just as the initial idea for this project was taking shape. His work with Helen Burns, PhD, RN, FAAN, then the University of Pittsburgh School of Nursing Associate Dean for Clinical Education, eventually led to a successful grant submission to HRSA.

## OVERVIEW / INSTRUCTIONS

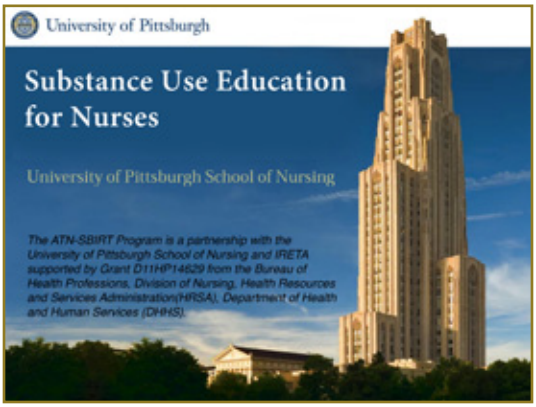
# SUBSTANCE USE EDUCATION FOR NURSES – JUNIOR COURSE -

## KEY TO ICONS

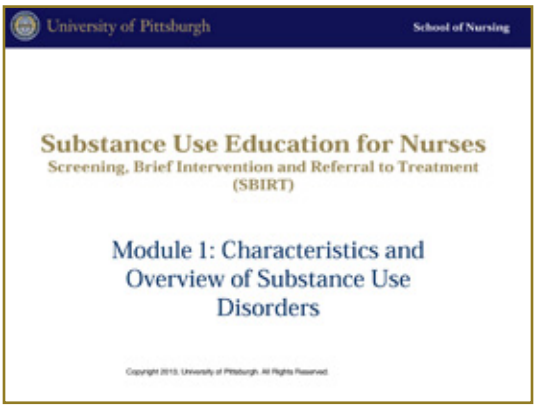
**The icon above relates to additional instructions for the trainer.**

**The icon above relates to activities for the group.**

**The icon above relates to additional reference material provided by the trainer.**

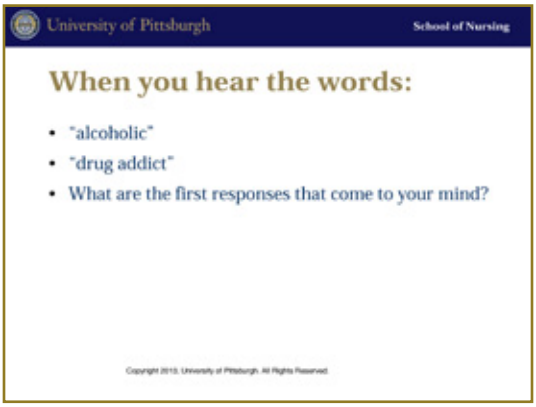



**1. TRAINER NOTE:**



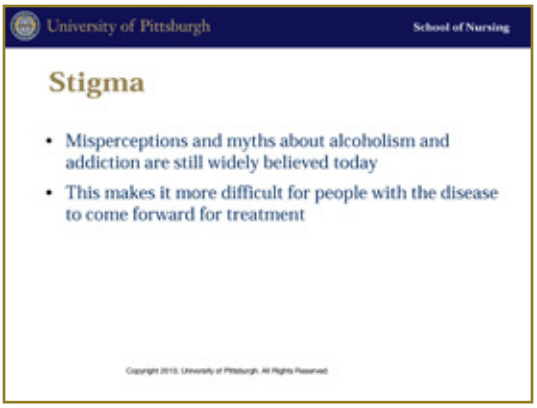

**2. TRAINER NOTE:**

This module will present an overview of addiction, discussing negative stereotypes about alcoholics and drug addicts that are sometimes barriers to providing healthcare for this population. It will also discuss what addiction is, its symptoms and how it affects individuals and society as a whole. It also presents the concept of addiction as a manageable disease, which includes the prospect of recovery for many people. It is not the "hopeless" condition that is often to be considered the case.



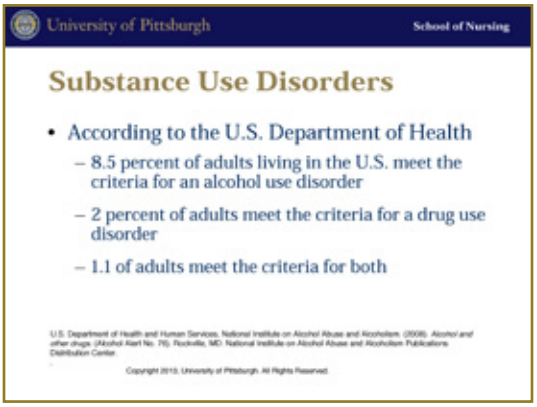

**3. TRAINER NOTE:**

The purpose of these slides is to evoke common stereotypes of alcoholics and addicts in participants.




**4. TRAINER NOTE:**

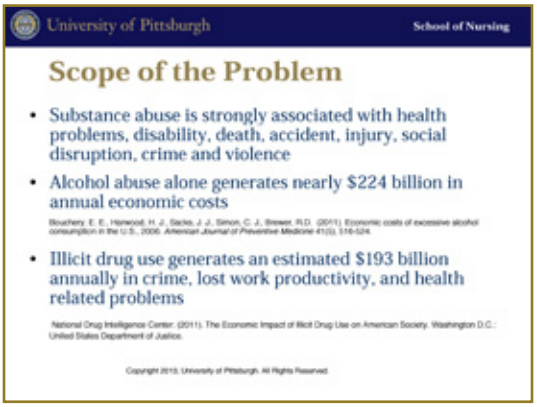
Emphasize that the stigma and stereotypes that accompanies addiction are barriers to patients seeking help for their drug and alcohol problems.




**5. TRAINER NOTE:**

Many individuals are either directly or indirectly impacted by Substance Use Disorders.

U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism. (2008). Alcohol and other drugs. (Alcohol Alert No. 76). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration.

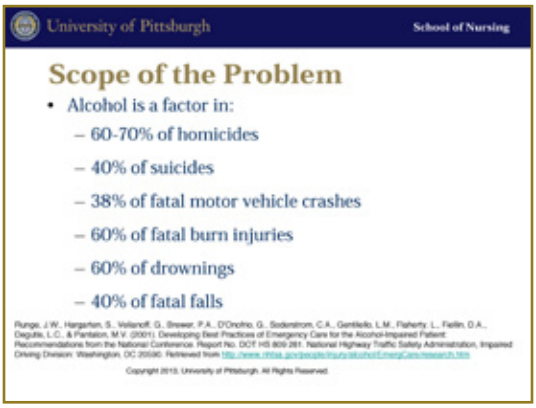



**6. TRAINER NOTE:** *Read the slide verbatim.*

Substance abuse is often a factor in health-related and social problems and it results in serious economic costs as well.

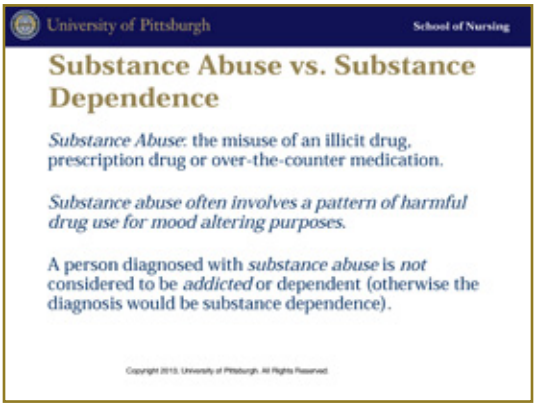
Bouchery, E.E., Harwood, H.J., Sacks, J.J., Simon, C.J., & Brewer, R.D. (2011). Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine, 41*(5), 516-524.

National Drug Intelligence Center. (2011). The Economic Impact of Illicit Drug Use on American Society. Washington D.C.: United States Department of Justice.



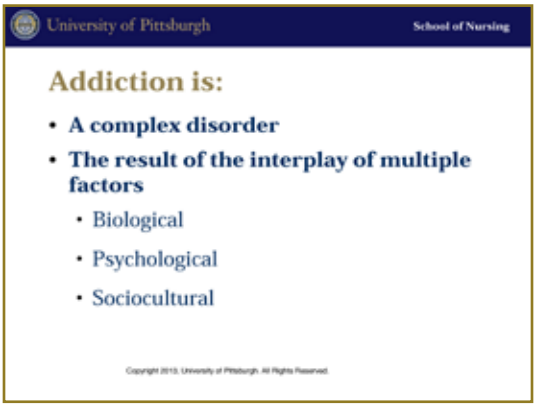

## 7. TRAINER NOTE:

Runge, J.W., Hargarten, S., Velianoff, G., Brewer, P.A., D'Onofrio, G., Soderstrom, C.A., Gentilello, L.M., Flaherty, L., Fiellin, D.A., Degutis, L.C., & Pantalon, M.V. (2001). Developing Best Practices of Emergency Care for the Alcohol-Impaired Patient: Recommendations from the National Conference. Report No. DOT HS 809 281. National Highway Traffic Safety Administration, Impaired Driving Division: Washington, DC 20590. Retrieved from http://www.nhtsa.gov/people/injury/alcohol/EmergCare/research.htm.



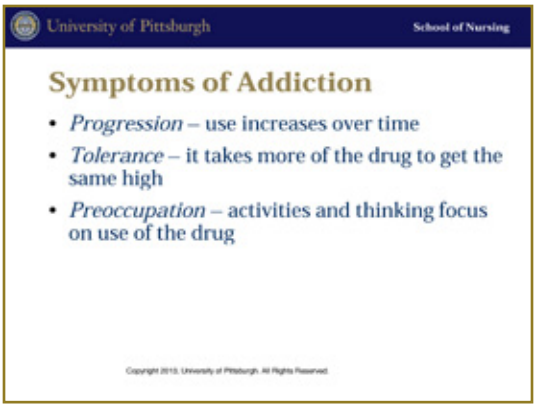

## 8. TRAINER NOTE:

Any prescription or over the counter medication that is not being used as directed is being misused. Physical dependence can occur even if certain medications (like pain medication) is being used as prescribed. Physical dependence does not mean addiction in such cases, as long as the medication is properly prescribed, the patient takes the medicine as prescribed and only for the period of time indicated. When it is time to stop the medication it should be tapered gradually under the supervision of a physician. However, it is important to stress that prescription pain medication is not benign or "safe". These medications should be used with great caution, understanding that the gap between physical dependence and addiction is not that wide.



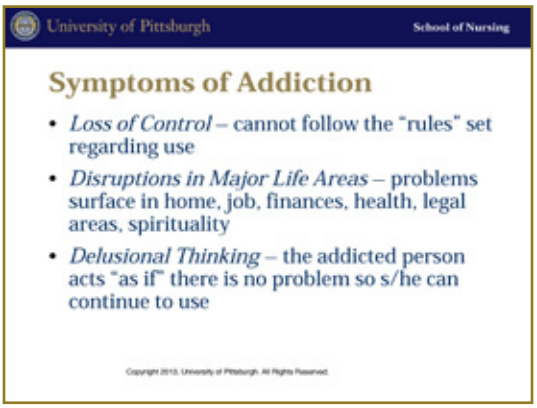

## 9. TRAINER NOTE:

The origin of an addiction is complex, variable and multifactoral. It arises from complex and ongoing interactions between biological, psychological and sociocultural factors. The combinations, interactions and weighting of specific factors differ for each addict.



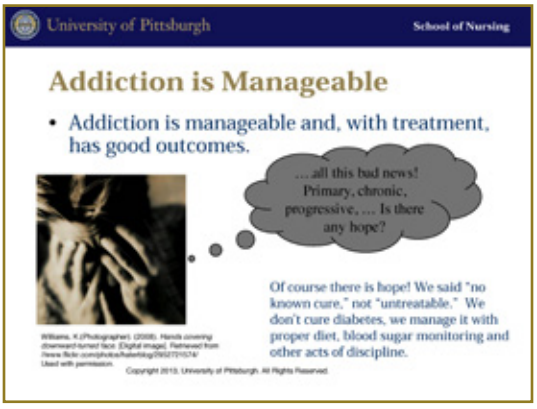

## 10. TRAINER NOTE:

The criteria typically used to assess addiction.



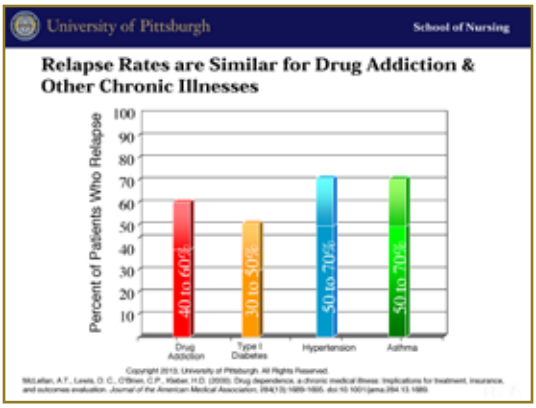

## 11. TRAINER NOTE:

The criteria typically used to assess addiction.




## 12. TRAINER NOTE:

Addiction can be treated and managed like other diseases. Relapses can and do often occur, as is the case with other chronic conditions. Relapse does not indicate failure, but warrants adjusting treatment interventions to help the patient get back on track. Many patients in long term recovery have had some relapses along the way, especially early on in the recovery process.



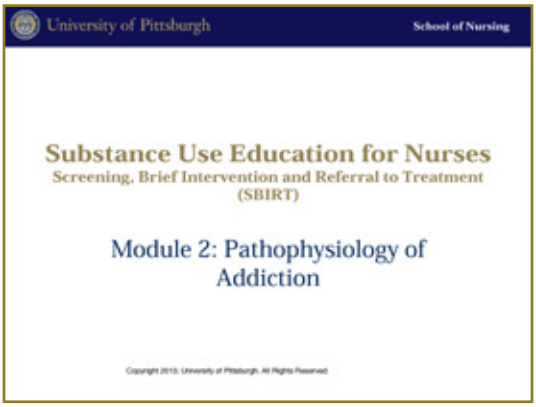

## 13. TRAINER NOTE:

Relapse rates for drug addiction are similar to those of other well-characterized chronic illnesses. This slide compares relapse rates for drug-addicted patients with those suffering from diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses (as is adherence to medication). Thus, drug addiction should be treated like any other chronic illness, with relapse serving as a trigger for renewed intervention. Perhaps because of the similarity in treatment adherence, there are also similar relapse rates across these disorders. Outcome studies indicate that 30% to 50% of adult patients with type 1 diabetes and approximately 50% to 70% of adult patients with hypertension or asthma experience recurrence of symptoms each year to the point where they require additional medical care to reestablish symptom remission.

McLellan, A.T., Lewis, D. C., O'Brien, C.P., Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13):1689-1695. doi:10.1001/jama.284.13.1689.

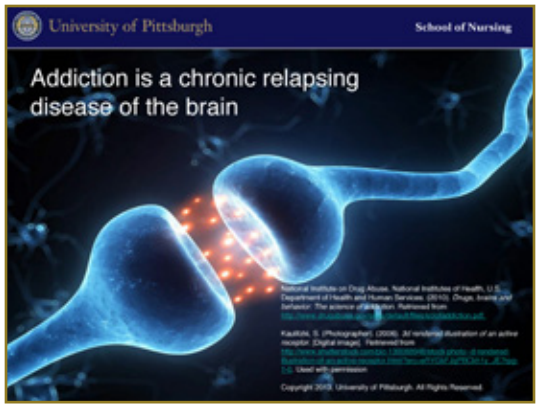

## 14. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.




## 15. TRAINER NOTE:

This module is primarily a discussion of how addiction works in the brain, especially the brain's reward system. Stressing the fact that substance abuse can alter the structure of the brain in such a way that the patient is now "hooked" on alcohol or drugs underscores the fact that choice about use/abuse becomes limited and beyond the control of the addict without serious behavior changes that often need to be supported by treatment.




## 16. TRAINER NOTE:

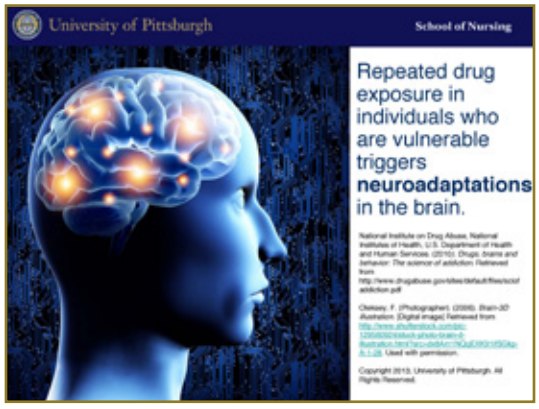
Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain - they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs.

National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services. (2010). Drugs, Brains and Behavior: The Science of Addiction. Retrieved from http://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf.


## 17. TRAINER NOTE:

Scientists estimate that genetic factors account for between 40 and 60 percent of a person's vulnerability to addiction, including the effects of environment on gene expression and function. Adolescents and individuals with mental disorders are at greater risk of drug abuse and addiction than the general population.

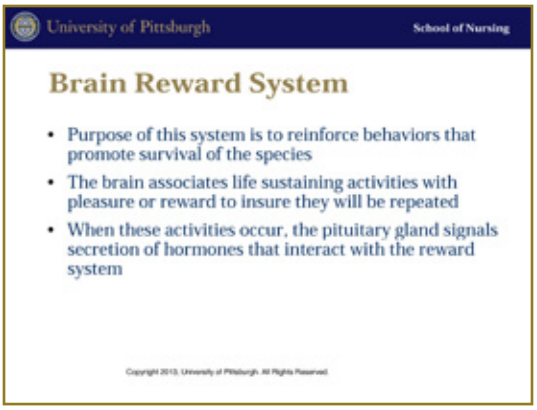
National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services. (2010). Drugs, Brains and Behavior: The Science of Addiction. Retrieved from http://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf.




## 18. TRAINER NOTE:

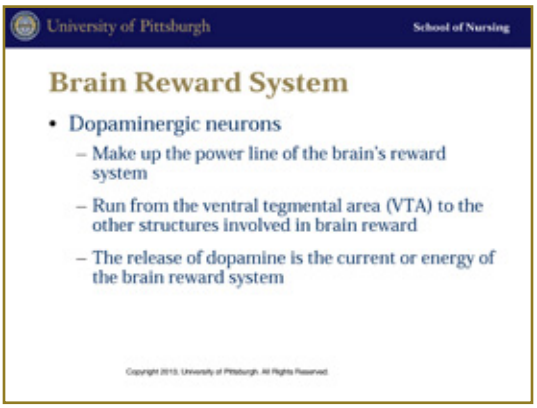
Similarly, long-term drug abuse can trigger adaptations in habit or nonconscious memory systems. Conditioning is one example of this type of learning, whereby environmental cues become associated with the drug experience and can trigger uncontrollable cravings if the individual is later exposed to these cues, even without the drug itself being available. This learned "reflex" is extremely robust and can emerge even after many years of abstinence.

National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services. (2010). Drugs, Brains and Behavior: The Science of Addiction. Retrieved from http://www.drugabuse.gov/sites/default/files/sciofaddiction.pdf.

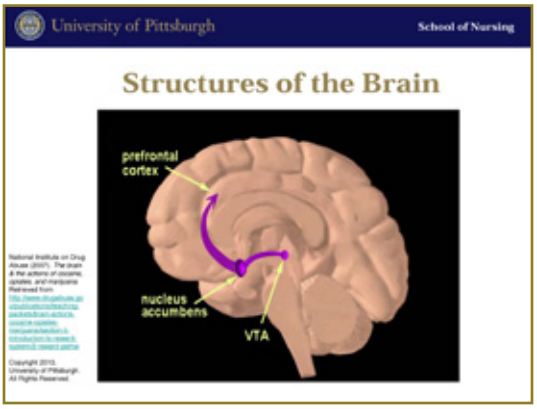



## 19. TRAINER NOTE:

Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this reward circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again, without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.



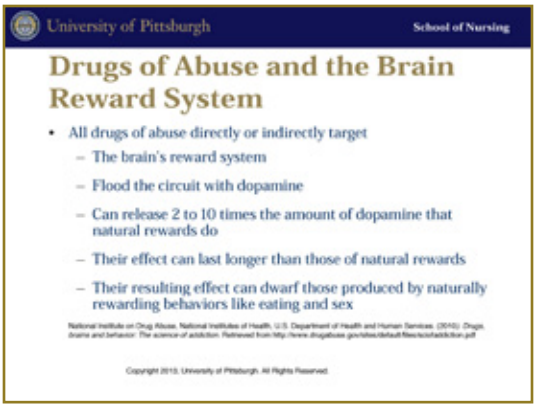

## 20. TRAINER NOTE:




## 21. TRAINER NOTE:

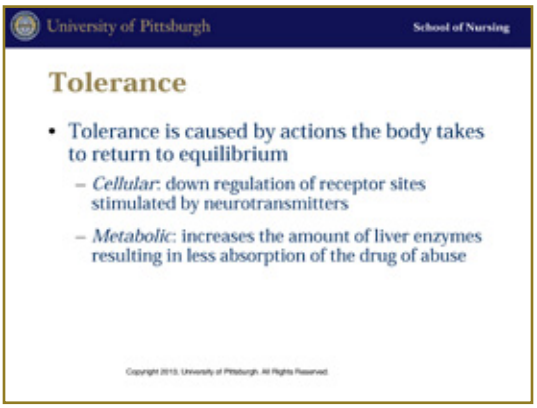
National Institute on Drug Abuse (2007). The brain & the actions of cocaine, opiates, and marijuana.

Retrieved from http://www.drugabuse.gov/publications/teaching-packets/brain-actions-cocaine-opiates-marijuana/section-ii-introduction-to-reward-system/2-reward-pathw



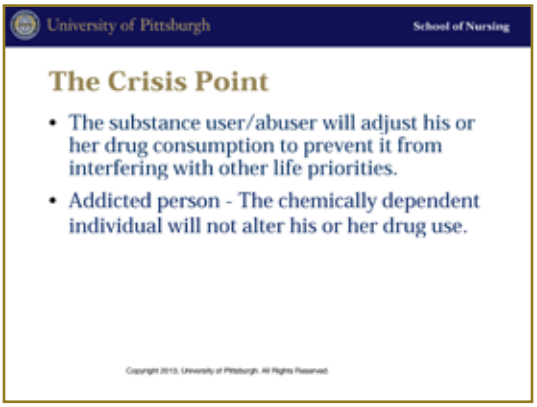

## 22. TRAINER NOTE:

National Institute on Drug Abuse. (2010). Drugs, brain, and behavior: The science of addiction. Retrieved from http://www.drugabuse.gov/publications/science-addiction.




## 23. TRAINER NOTE:

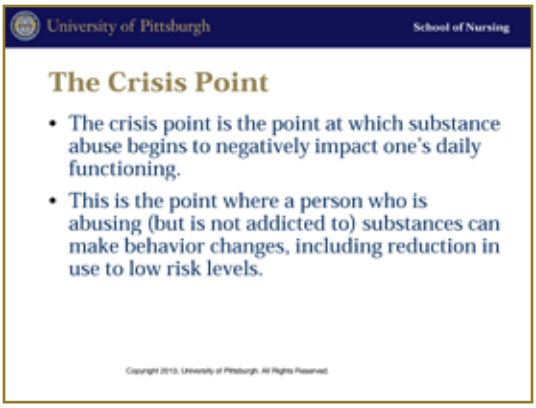
Tolerance is a very important note of the development of addiction. The fact that a person may be able to "drink others under the table" is not a good sign at all. People who can still function with high alcohol blood alcohol content are a risk to themselves and others and are likely to experience serious health problems.




## 24. TRAINER NOTE:

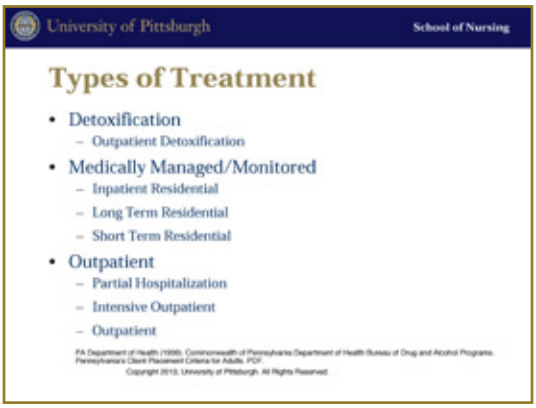
The substance user/abuser will adjust his or her drug consumption to prevent it from interfering with other life priorities.

The chemically dependent individual will not alter his or her drug use.




## 25. TRAINER NOTE:

The crisis point is the point at which substance abuse begins to negatively impact one's daily functioning. This is the point where a person who is abusing (but is not addicted to) substances can make behavior changes, including reduction in use to low risk levels.




## 26. TRAINER NOTE:

**Detoxification** is the process whereby a drug or alcohol intoxicated or dependent patient is assisted through the period of time needed to eliminate (by metabolic or other means) the presence of the intoxicating substance or the dependency factors, while keeping the physiological or psychological risk to the patient at a minimum.

**Medically Managed Inpatient Residential** treatment provides 24-hour medically directed evaluation, care and treatment for addicted patients with coexisting biomedical, psychiatric and/or behavioral conditions which require frequent care. Facilities for such services need to have, at minimum, 24-hour nursing care, 24-hour access to specialize medical care and intensive medical care, and 2-hour access to physician care.

**Medically Monitored Long Term Residential** treatment is a type of service that includes 24-hour professionally directed evaluation, care, and treatment fro addicted patients in chronic distress, whose addiction symptomatolgy is demonstrated by severe impairment of social, occupational or school functioning.

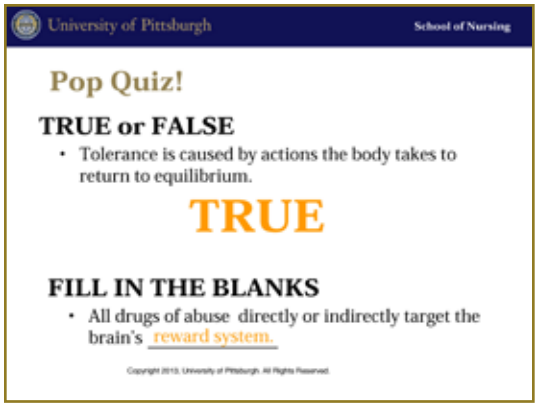
**Medically Monitored Short Term Residential** treatment is a type of service that includes 24-hour professionally directed evaluation, care and treatment for addicted patients in acute distress.

**Partial Hospitalization** treatment consists of the provision of psychiatric, psychological and other types of therapies on a planned and regularly scheduled basis in which the patient resides outside the facility. This service is designed for those patients who do not require 24-hour residential care but who would nontheless benefit from more intensive treatments than are offered in outpatient treatment projects.

**Intensive Outpatient** treatment is an organized, non-residential treatment service in which the patient resides outside the facility. The services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 day per week for at least 5 hours (but less than 10).

**Outpatient** treatment… provides psychotherapy… in regularly scheduled treatment sessions for at most 5 hours per week.

PA Department of Health (1999). Commonwealth of Pennsylvania Department of Health Bureau of Drug and Alcohol Programs. Pennsylvania's Client Placement Criteria for Adults. PDF.




## 27. TRAINER NOTE:

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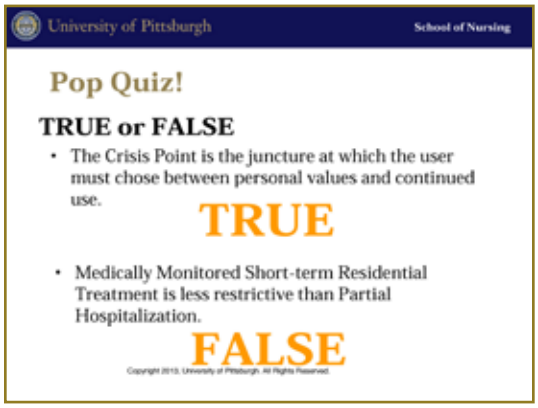


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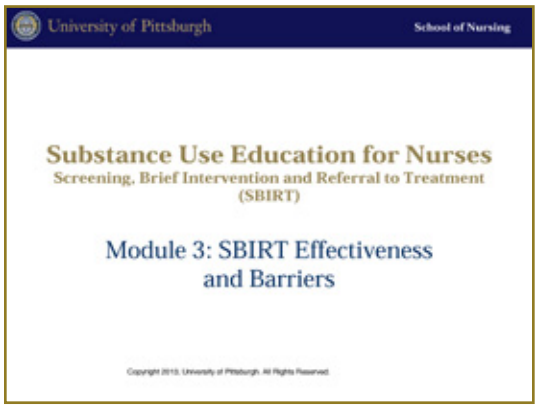
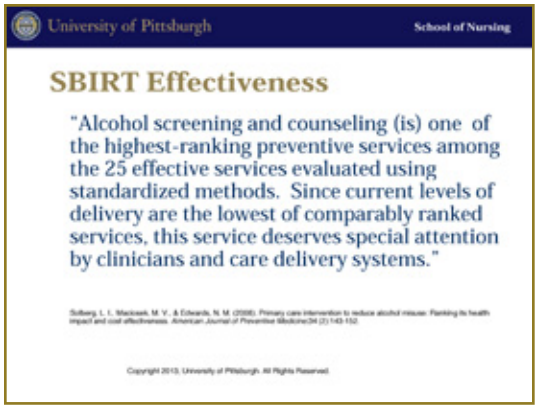



## 29. TRAINER NOTE:

This module will present information about the effectiveness of Screening, Brief Intervention and Referral to Treatment (SBIRT). It will also address some of the barriers to its adoption in healthcare settings, as well as the important role healthcare providers have in implementing this effective protocol.



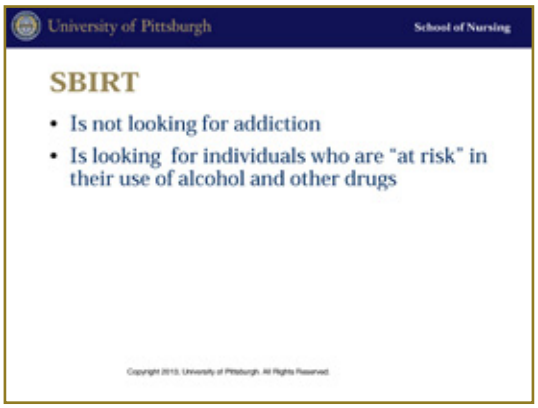

## 30. TRAINER NOTE:

Solberg, L. I., Maciosek, M. V., & Edwards, N. M. (2008). Primary care intervention to reduce alcohol misuse: Ranking its health impact and cost effectiveness. *American Journal of Preventive Medicine*;34 (2):143-152.


## 31. TRAINER NOTE:

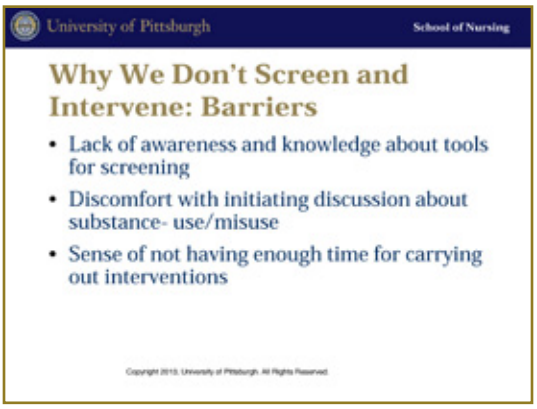
The efficacy of SBIRT was supported by a multinational study conducted by the World Health Organization.

American Journal of Public Health (1996). A cross-national trial of brief interventions with heavy drinkers. WHO brief intervention study group. *American Journal of Public Health*, 86(7): 948-955.




## 32. TRAINER NOTE:

SBIRT is designed to identify at-risk rather than addicted individuals.

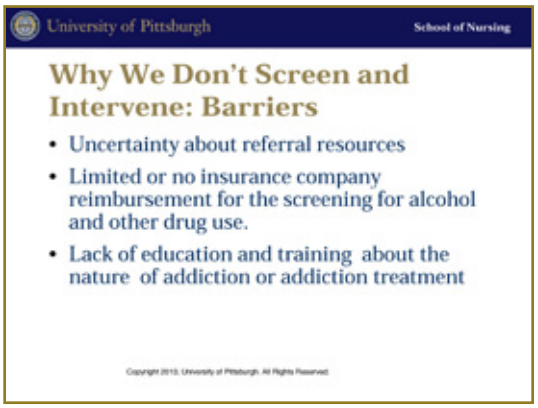



**33. TRAINER NOTE:**

Ask the students to list the various barriers that prevent health care workers from conducting drug/alcohol assessments and interventions, before showing the items mentioned on the slides.


**34. TRAINER NOTE:**

Ask the students to list the various barriers that prevent health care workers from conducting drug/alcohol assessments and interventions, before showing the items mentioned on the slides.

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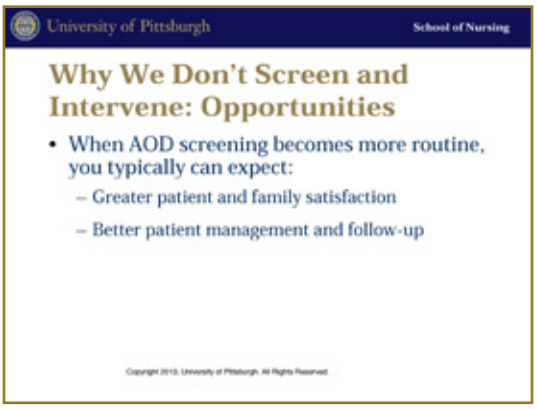
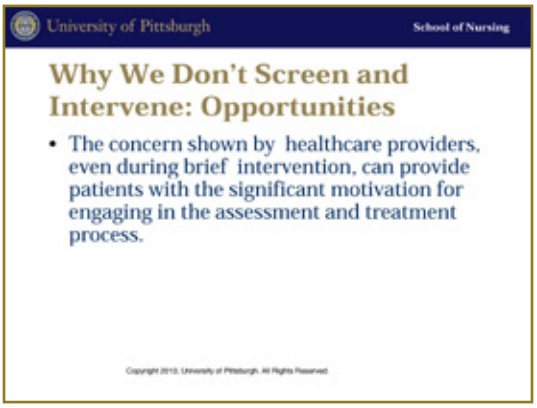


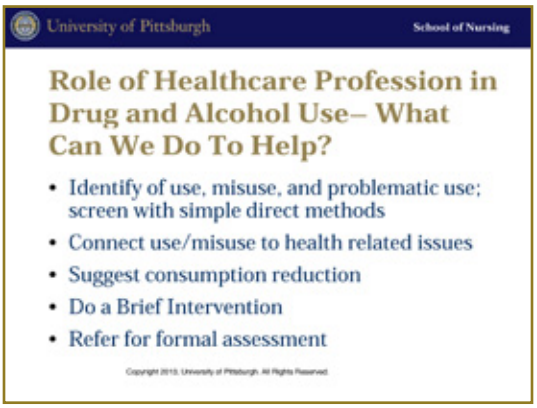

## 36. TRAINER NOTE:

Students may be skeptical the "greater patient and family satisfaction" can result from an alcohol screen. Stress that many patients might not be aware that they are drinking at risky levels and will feel grateful that the healthcare professional has taken time to discuss this with them in a calm and caring manner, since their use bears directly on their health-related issues.



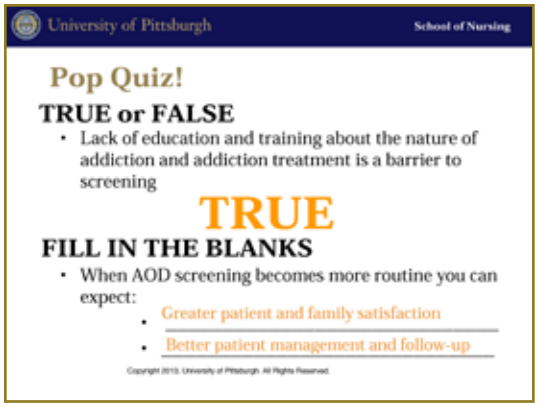

## 37. TRAINER NOTE:

Nurses are considered to be the most trusted healthcare professional, so patients will take to heart what they say.




## 38. TRAINER NOTE:

Ask the students to share their thoughts on "What we can do to help" before discussing the items listed on the slide.




## 39. TRAINER NOTE:

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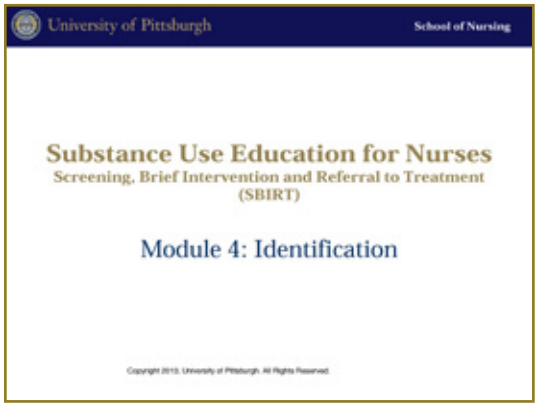
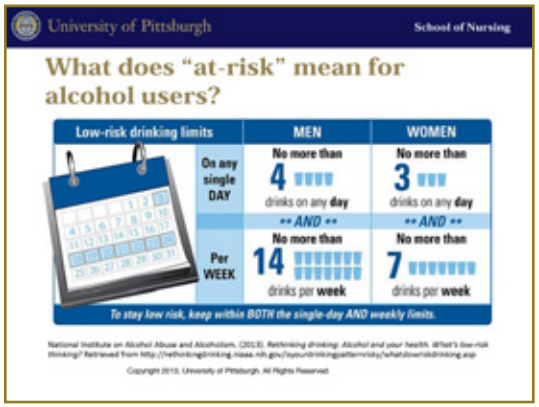


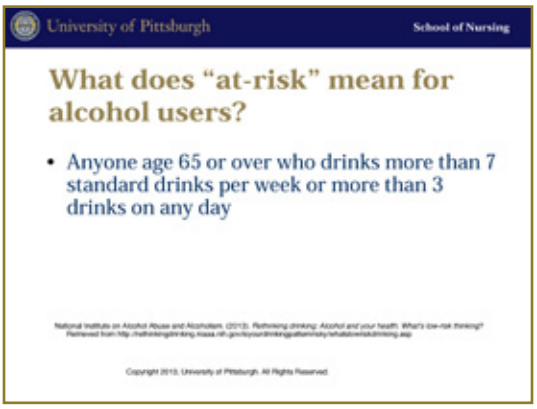

## 40. TRAINER NOTE:

This module presents important information about how to identify at risk users. It defines what "at risk" alcohol use means, what category of risk percentages of people fall into, what constitutes a "standard drink", what do we mean by binge drinking leading to an identification of problem drinkers verses those who are possibly dependent. This will set the stage for a discussion of screening techniques that will be helpful in identifying who will benefit from which level of intervention in the SBIRT model.



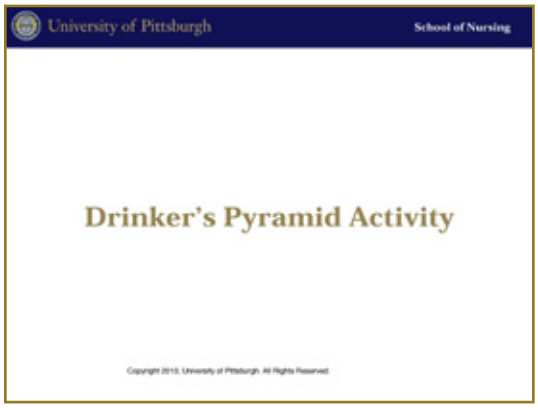

## 41. TRAINER NOTE:

National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking drinking: Alcohol and your health. What's low-risk thinking? Retrieved from http://rethinkingdrinking.niaaa.nih.gov/isyourdrinkingpatternrisky/whatslowriskdrinking.asp




## 42. TRAINER NOTE:

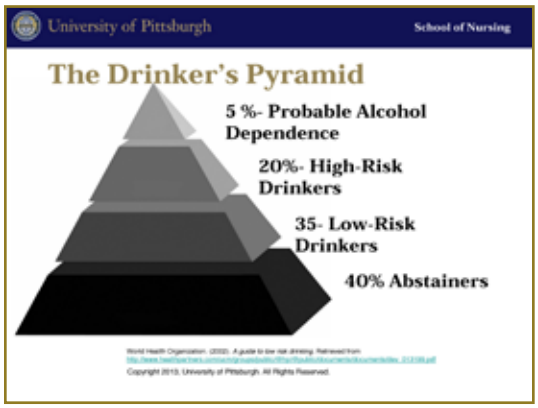
National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking drinking: Alcohol and your health. What's low-risk thinking? Retrieved from http://rethinkingdrinking.niaaa.nih.gov/isyourdrinkingpatternrisky/whatslowriskdrinking.asp




## 43. TRAINER NOTE:

Drinkers pyramid exercise:

Ask the students to form small groups (3 or 4). Pass out envelopes containing slips of paper with the following percentages (one percentage to each small slip of paper): 3-7%; 10-15% 35-40%; 40%. Also place in the envelope another set of small slips of paper with the following Drinker's Pyramid categories on them: Alcohol dependent or harmful users; Hazardous or at-risk users; Low-risk users; Abstainers. Then ask the groups to decide which percentage goes with which category of drinkers. Have each group report on their conclusions before revealing the World Health Organization information on the next slide.




## 44. TRAINER NOTE:

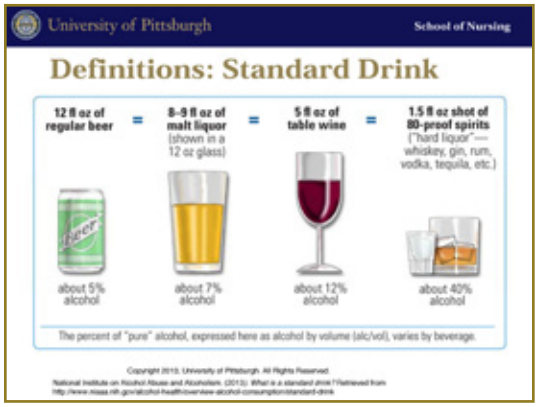
Show students the Drinker's Pyramid and process the exercise, emphasizing the number of individuals who abstain from alcohol or are at-risk drinkers is significantly lower than those who engage in at-risk or harmful alcohol use.

Note: Many individuals who abstain from alcohol use belong to religious groups that prohibit alcohol consumption.

World Health Organization. (2002). A guide to low risk drinking. Retrieved from http://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_013199.pdf

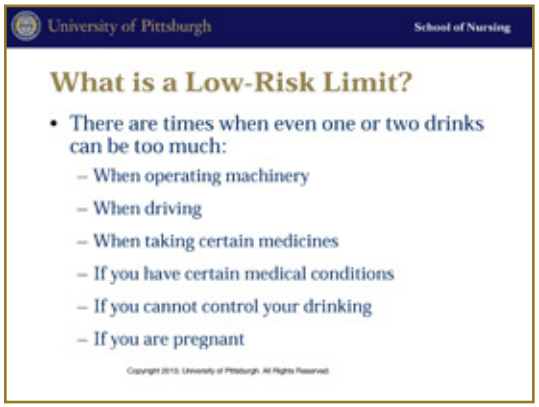

## 45. TRAINER NOTE:

Before showing the students the next slide (Definitions of a Standard Drink), draw a receptacle on a white board and divide it with lines indicating 1 thru 16 ounces. Then invite a student to come up and mark which line (number of ounces) indicates a standard drink of beer, then wine, then a shot of spirits ("hard liquor"). If you don't have access to a white board, just ask students to estimate how many ounces constitutes a standard drink of beer, wine and spirits.



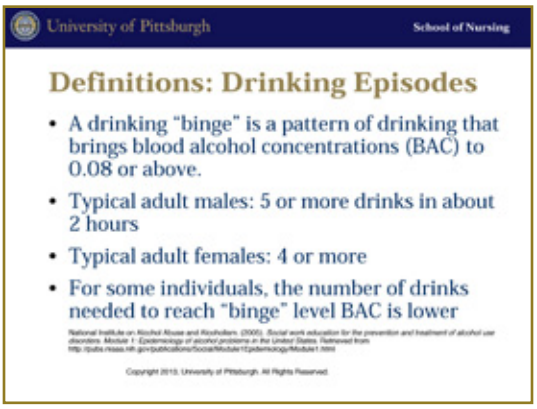

## 46. TRAINER NOTE:

National Institute on Alcohol Abuse and Alcoholism. (2013). What is a standard drink? Retrieved from http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/standard-drink




## 47. TRAINER NOTE:

Acknowledge that there are some situations, like those listed on this slide, when individuals should avoid any alcohol consumption. See if the students have suggestions for others.




## 48. TRAINER NOTE:

It is important to recognize that for some individuals, harmful drinking may only occur on one or two occasions during the month or year.

Even though infrequent, this type of alcohol consumption can have significant harmful consequences for an individual's health and well-being.

In February, 2004 the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Advisory Council Task Force issued recommendations regarding the definition of "binge drinking." This definition is not dependent on the number of drinks consumed, nor is it related to the time frame of drinking session. It is based on drinking behaviors that raise an individual's blood alcohol concentration (BAC) up to or above the level of 0.08 gm%. This is typically reached for men with 5 or more drinks in about 2 hours, and for women with 4 or more drinks.

In the above definition, a "drink" refers to half an ounce of alcohol (e.g., one 12 oz. beer, one 5 oz. glass of wine, one 1 ½ oz. shot of distilled spirits).

Binge drinking is distinct is distinct from "risky" drinking (reaching a peak BAC between .05 gm% and .08 gm%) and a "bender" (2 or more days of sustained heavy drinking).

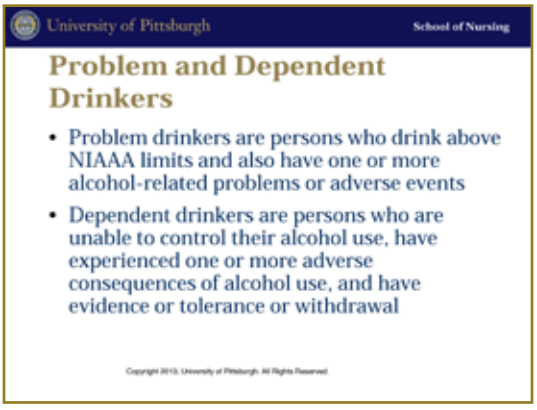
For some individuals (e.g., older people; those taking other drugs or certain medications), the number of drinks needed to reach a binge-level BAC is lower than for the "typical adult."

People with risk factors for the development of alcoholism have increased risk with any alcohol consumption, even that below a "risky" level.

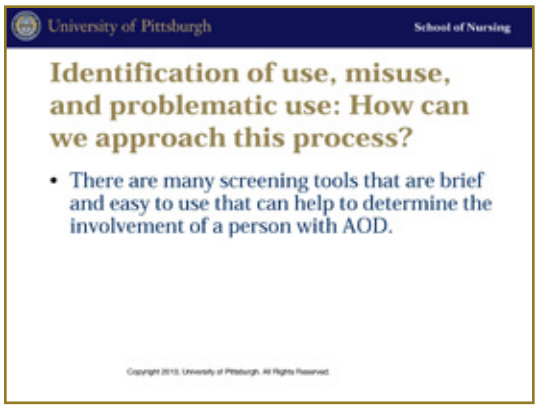
For pregnant women, any drinking presents risk to the fetus.

Drinking by persons under the age of 21 is illegal.

National Institute on Alcohol Abuse and Alcoholism. (2005). Social work education for the prevention and treatment of alcohol use disorders. Module 1: Epidemiology of alcohol problems in the United States. Retrieved from http://pubs.niaaa.nih.gov/publications/Social/Module1Epidemiology/Module1.html

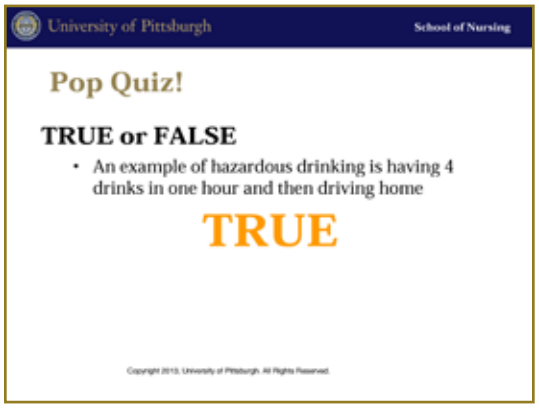



## 49. TRAINER NOTE:




**50. TRAINER NOTE:**

Emphasize the importance of using assessment tools in order to have some standardized method to distinguish among use, misuse and problematic use.




**51. TRAINER NOTE:**

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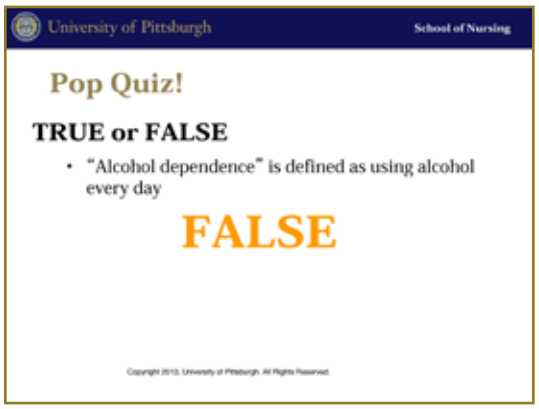


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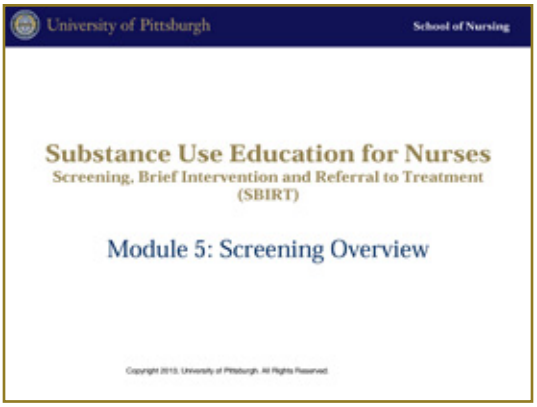


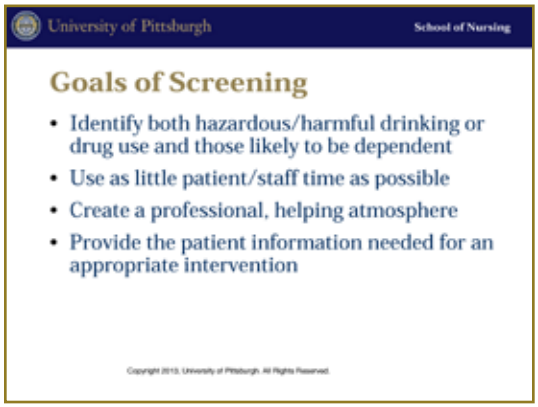

## 53. TRAINER NOTE:

This module will introduce a number of screening tools that are used in SBIRT. It will discuss how to score the screens and what the scores mean. Special emphasis will be placed on the Alcohol Use Disorders Identification Test (AUDIT). The students will be asked to practice using this screen in a role play.


## 54. TRAINER NOTE:

Invite students to discuss the various screening tools that they are already using and their level of comfort using them, including screens like taking a temperature or blood pressure reading, weight, family history of illness, etc.

Acknowledge that one's comfort with screening tools and talking to patients about their alcohol and drug use increases with experience.

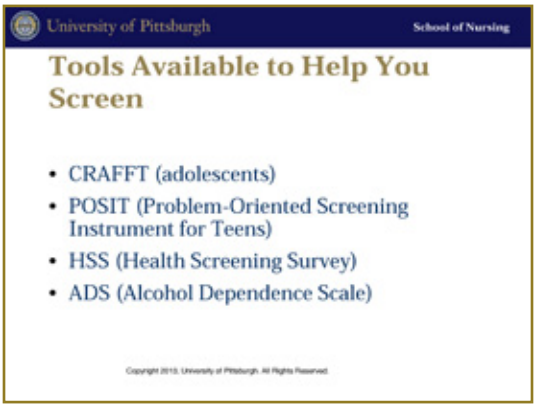



## 55. TRAINER NOTE:

Help the students understand that the goals of screening are limited. Screening is not the same as diagnosis or even assessment. High scores on a screen should lead to further assessment that may or may not lead to a diagnosis of addiction.


## 56. TRAINER NOTE:

A list of a variety of drug and/or alcohol screening tools designed for specific populations.



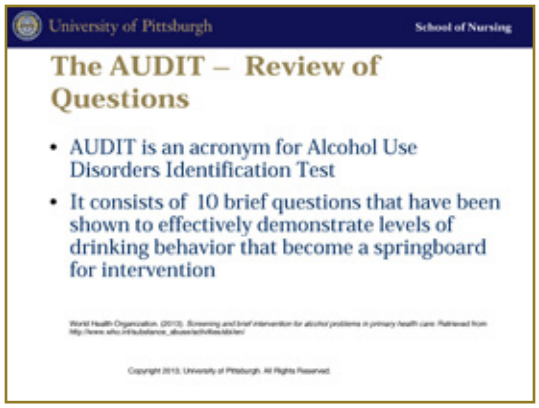

## 57. TRAINER NOTE:

A list of a variety of drug and/or alcohol screening tools designed for specific populations.


## 58. TRAINER NOTE:

Pre-Screens can be used as a quick way to determine whether or not a patients should be given a more complete screen, like the AUDIT or the DAST. Both the NIAAA and NIDA have developed one question screens. If a patient reports one or more occurrences on either screen this should trigger more in-depth screening or even a brief intervention.

Both references: National Institute on Alcohol Abuse and Alcoholism. (2007). *Helping patients who drink too much: A clinician's guide.* (NIH Publication No. 07-3769)

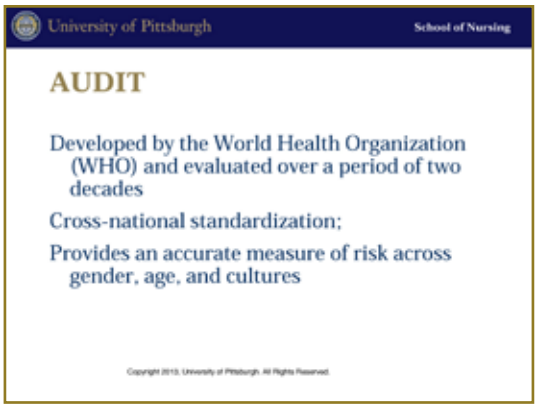



## 59. TRAINER NOTE:

Introduces the AUDIT, the primary screening tool used for SBIRT

- Describe the AUDIT
- Alcohol Use Disorders Identification Test
- Series of ten brief questions
- Developed by World Health Organization
- Normed across various cultures, genders, and ages
- Designed specifically to be used in primary care
- Can distinguish among low-risk, harmful and dependent use
- Addresses recent alcohol use

World Health Organization. (2013). Screening and brief intervention for alcohol problems in primary health care. Retrieved from http://www.who.int/substance_abuse/activities/sbi/en/

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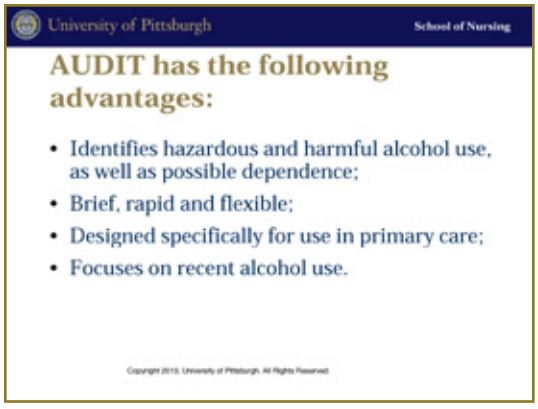


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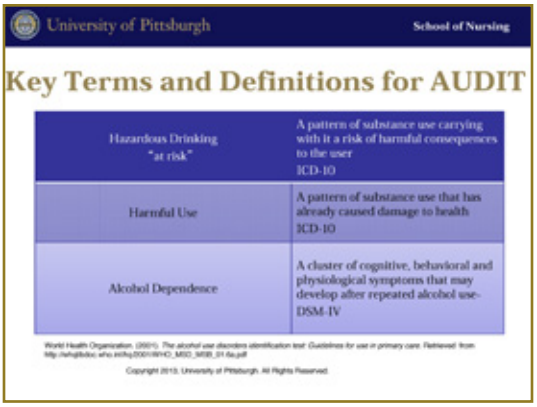
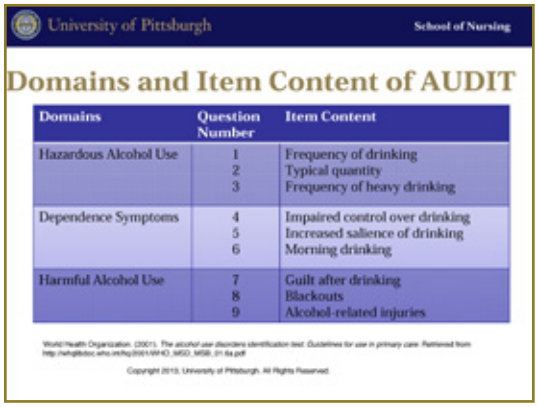



## 62. TRAINER NOTE:

Distinguishing the difference in how hazardous, harmful and dependent alcohol use are defined is necessary in understanding the significance of the results of an AUDIT.

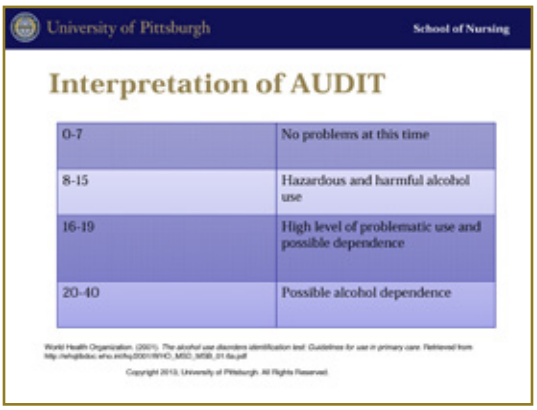
World Health Organization. (2001). The alcohol use disorders identification test: Guidelines for use in primary care. Retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf




## 63. TRAINER NOTE:

Identifies the types of questions on the AUDIT used to identify hazardous, harmful and dependent alcohol use.

World Health Organization. (2001). The alcohol use disorders identification test: Guidelines for use in primary care. Retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

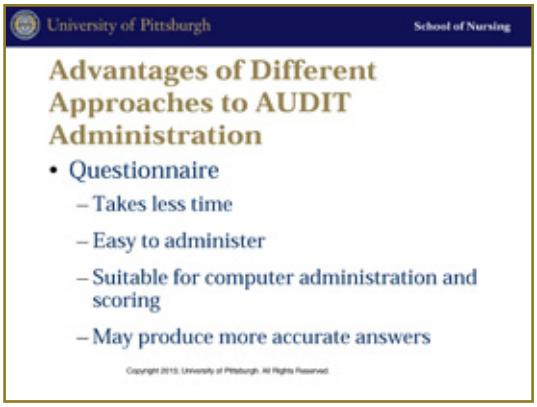



## 64. TRAINER NOTE:

Defines what the various scores on the AUDIT mean.

Majority of patients score below 8 indicated low-risk drinking. No intervention is required; however, alcohol education is appropriate.

World Health Organization. (2001). The alcohol use disorders identification test: Guidelines for use in primary care. Retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf




## 65. TRAINER NOTE:

Contrasts the value of administering the AUDIT via a paper and pencil questionnaire versus an interview.

Key points for questionnaire

- Easy
- Less time
- Some individuals may give more accurate answers

Key points for interview

- The non-judgmental approach used by the interviewer can establish the relationship needed to conduct an intervention
- The interviewer can clarify ambiguous questions
- Avoids embarrassing individuals with low literacy levels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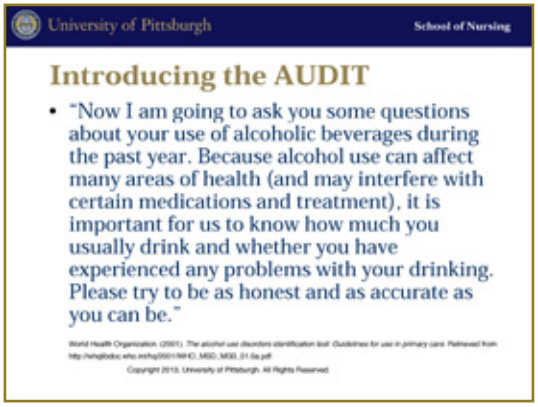
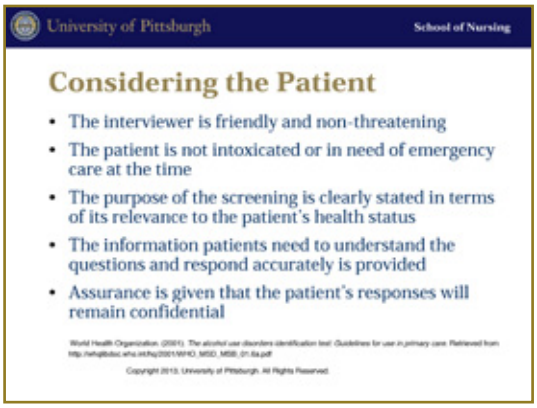



## 67. TRAINER NOTE:

Provides an example of how a health care professional can introduce the AUDIT in a primary care setting. Students should be directed to develop their own less formal introduction based on the concepts contained in this script.

World Health Organization. (2001). The alcohol use disorders identification test: Guidelines for use in primary care. Retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

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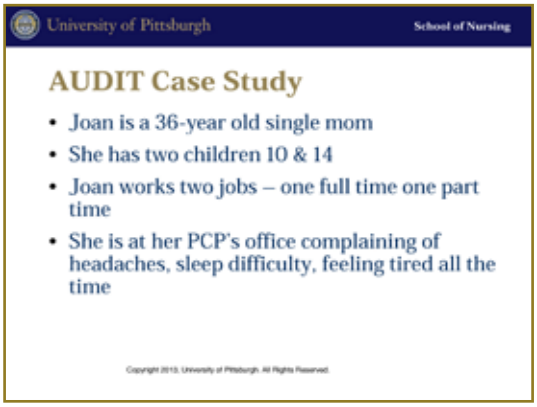
World Health Organization. (2001). The alcohol use disorders identification test: Guidelines for use in primary care. Retrieved from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf.




## 69. TRAINER NOTE:

Conduct a roleplay of how to introduce and administer the AUDIT

Prior to the roleplay ask for a student volunteer to play a patient and tell the students that you will provide the volunteer with background information for the patient.

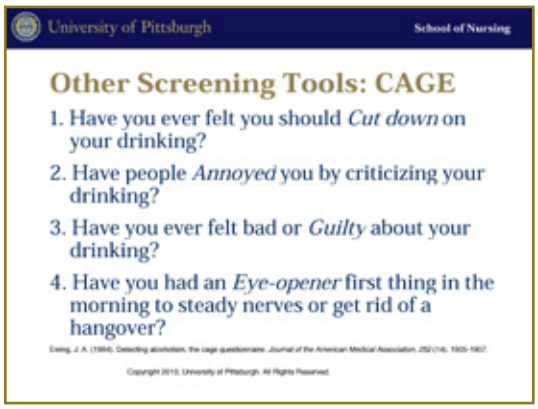
Once a student has volunteered to roleplay a patient, provide the class with the background information on the patient (see the next slide).

Ask the students in the audience to try to score the AUDIT individually as they listen to the roleplay.

Demonstrate how one can ask the questions on the AUDIT in a normal conversation with the patient.

Once the roleplay is complete, thank the volunteer and ask the class if they were able to score the AUDIT (the individual should either score a 6 or a 7, depending on the information provided by the volunteer during the roleplay).

Ask students to provide you with feedback on what you did during the roleplay that they liked and if there was anything that they wished you would have done differently.




## 70. TRAINER NOTE:

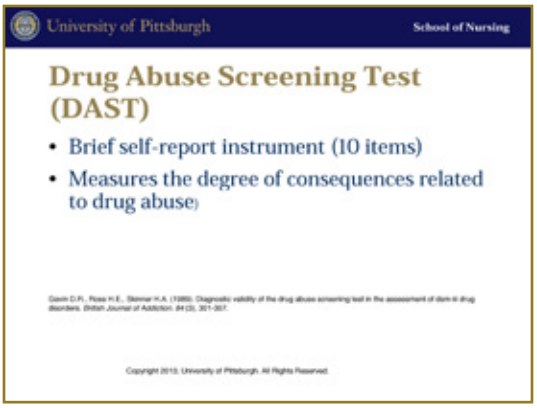
Advantages

- Brief and non-confrontational
- Widely used and validated
- Sensitive and specific for alcoholism
- No training required for administration

Limitations

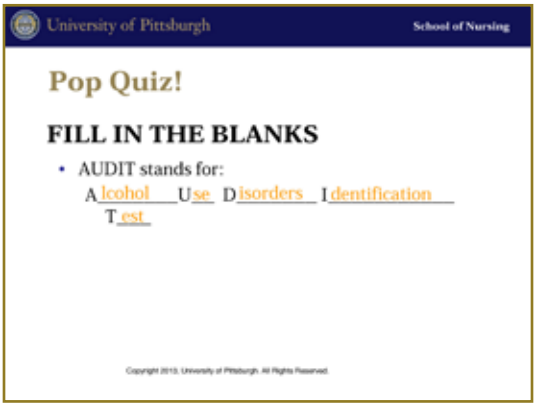
- Not validated for pain patients
- Shown to be less specific and accurate than other more extensive screening tools, such as the AUDIT (Magruder-Habib et al. 1993).
- Less accurate in adolescents (Knight et al. 2003), women and minority populations (Volk et al. 2007).

Ewing, J. A. (1984). Detecting alcoholism, the cage questionnaire. *Journal of the American Medical Association*, 252 (14), 1905-1907.




## 71. TRAINER NOTE:

Gavin D.R., Ross H.E., Skinner H.A. (1989). Diagnostic validity of the drug abuse screening test in the assessment of dsm-iii drug disorders. *British Journal of Addiction* 84(3), 301-307.




## 72. TRAINER NOTE:

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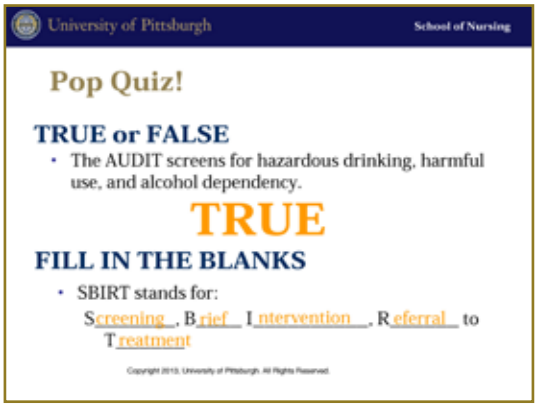
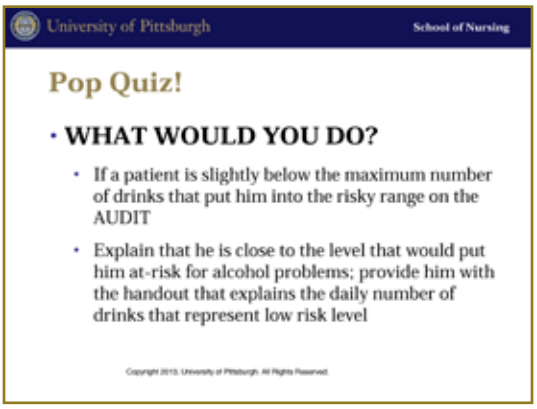


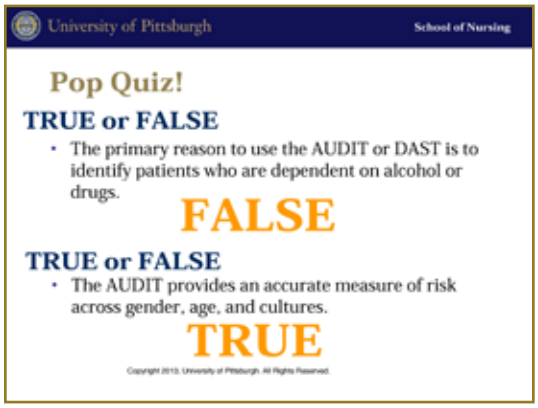

## 73. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.



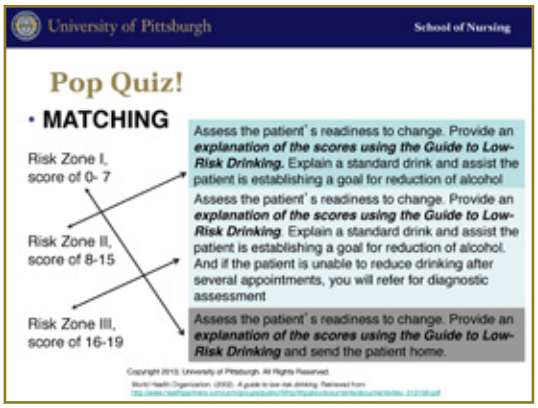

## 74. TRAINER NOTE:

For this "Pop Quiz" , the first click will bring up the question (give the students time to answer) and the second click with reveal the answer.




## 75. TRAINER NOTE:

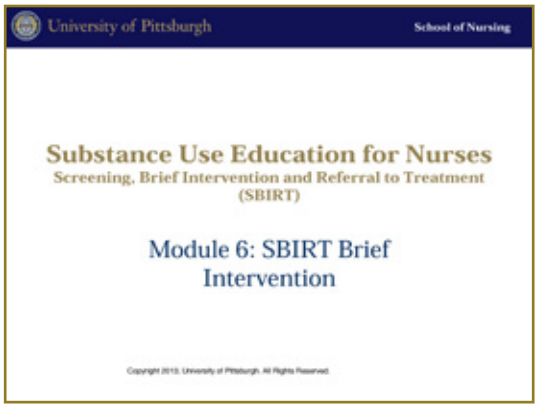
For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.




## 76. TRAINER NOTE:

For this quiz, ask the students to take a minute to read the descriptions on the right had side of the slide, then ask which one goes with Risk Zone 1. Then click and an arrow connecting Risk Zone 1 with the correct answer will appear. Continue until all the Risk Zones are accounted for.

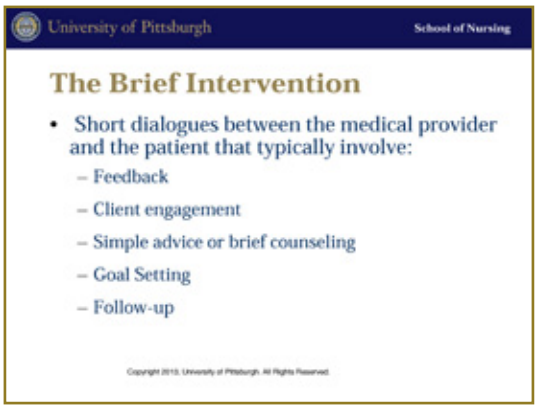
World Health Organization. (2002). A guide to low risk drinking. Retrieved from http://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/dev_013199.pdf




## 77. TRAINER NOTE:

This module will explain what a brief intervention is and describe how it is done. It will include video demonstrations, an activity and a role play. Stress that the brief intervention is an opportunity for the healthcare provider to help the patient make behavior changes related to their use of alcohol and drugs that will result in better health outcomes. In addition, the brief intervention describes a way for healthcare providers to talk to patients about their use in an non-judgmental way.

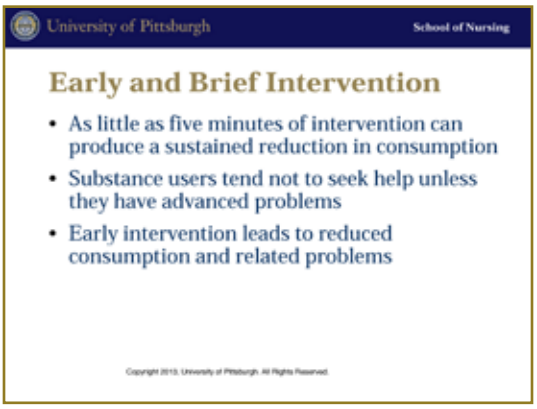

## 78. TRAINER NOTE:




## 79. TRAINER NOTE:

A brief intervention:

- Supplies the patient with the information gained from the screening process
- Uses skills to engage the patient
- Provides simple advice or brief counseling on how to reduce any harmful effects of his or her substance use
- Helps the client to establish a goal to reduce substance use related harm
- Offers follow-up

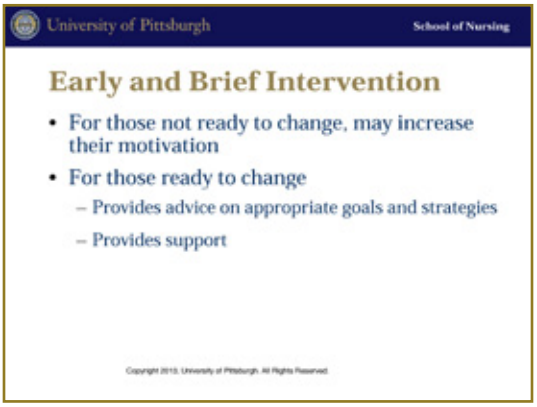



## 80. TRAINER NOTE:

A brief intervention can be as short as 5 minutes.

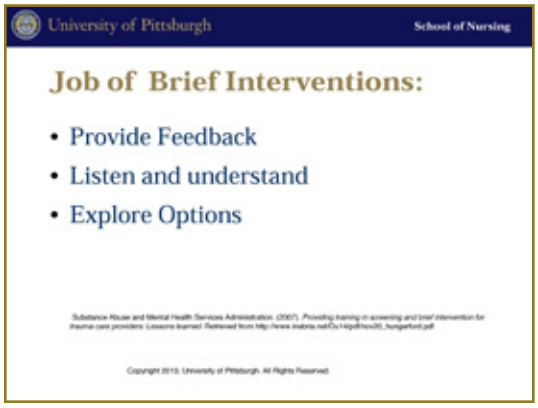
For those not ready to change, it can increase their awareness that a problem exists.

For those ready to change, brief interventions can provide advice and support for adopting goals and strategies to reduce substance-related harm.




## 81. TRAINER NOTE:

Brief interventions can either motivate individuals to begin to consider the possibility of change or to identify both what and how to change.




## 82. TRAINER NOTE:

Identifies the 3 primary goals of a brief intervention.

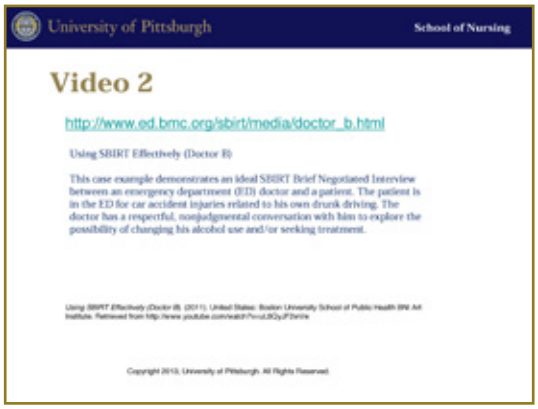
Substance Abuse and Mental Health Services Administration. (2007). Providing training in screening and brief intervention for trauma care providers: Lessons learned. Retrieved from http://www.inebria.net/Du14/pdf/nov20_hungerford.pdf


## 83. TRAINER NOTE:

Inform students that they will now have an opportunity to view videos demonstrating a health care worker conducting a brief intervention with a patient.

Ask them as they watch to note anything that the health care worker did with the patient that was effective or not effective.

Anti-SBIRT (Doctor A). (2011). United States: Boston University School of Public Health BNI Art Institute. Retrieved from http://www.youtube.com/watch?v=ZGETDcFcAbI




## 84. TRAINER NOTE:

Inform students that they will now have an opportunity to view videos demonstrating a health care worker conducting a brief intervention with a patient.

Ask them as they watch to note anything that the health care worker did with the patient that was effective or not effective.

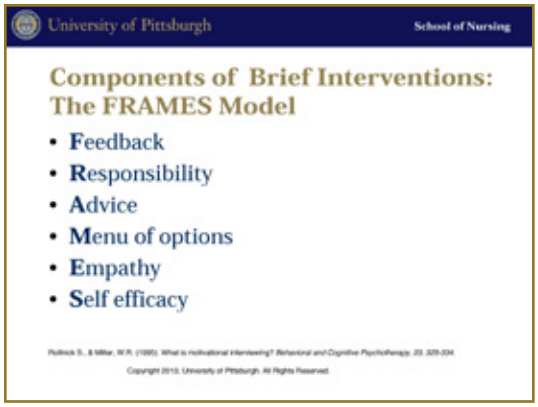
Using SBIRT Effectively (Doctor B). (2011). United States: Boston University School of Public Health BNI Art Institute. Retrieved from http://www.youtube.com/watch?v=uL8QyJF2wVw


## 85. TRAINER NOTE:

Inform students that they will now have an opportunity to view videos demonstrating a health care worker conducting a brief intervention with a patient.

Ask them as they watch to note anything that the health care worker did with the patient that was effective or not effective.

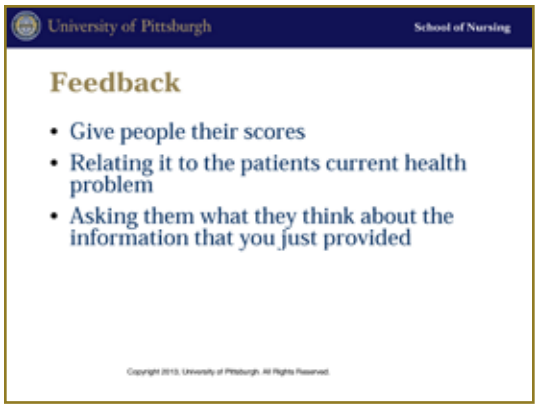
SBIRT for alcohol use: college student. (2011). United States: Boston University School of Public Health BNI Art Institute. Retrieved from http://www.youtube.com/watch?v=SvqjTOnp_SM




## 86. TRAINER NOTE:

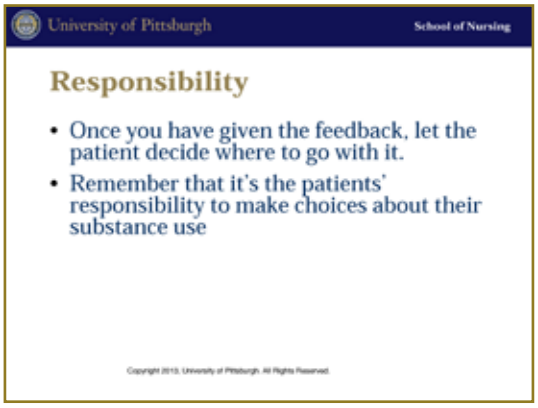
Identifies the components of a brief intervention.

Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? Behavioral and Cognitive Psychotherapy, 23, 325-334.




## 87. TRAINER NOTE:

The goal is to provide objective feedback regarding the patient's score on the screen that was just administered and how it relates to the patient's current health problem.



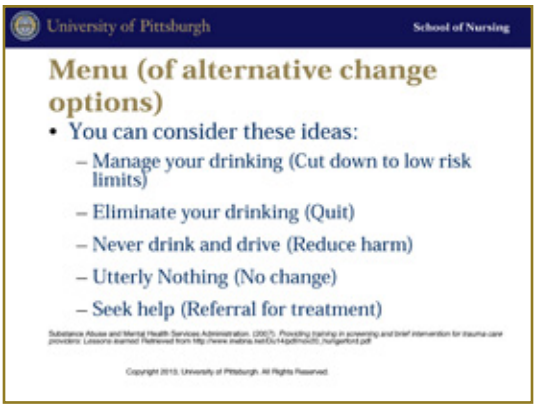

## 88. TRAINER NOTE:

The goal is to provide objective feedback regarding the patient's score on the screen that was just administered and how it relates to the patient's current health problem.


## 89. TRAINER NOTE:

Emphasize the importance of asking the patient if s/he is open to advice about behavior change before giving it.

Asking for permission demonstrates respect and allows the patient to have control, which helps to keep patients open to any suggestions that are made.

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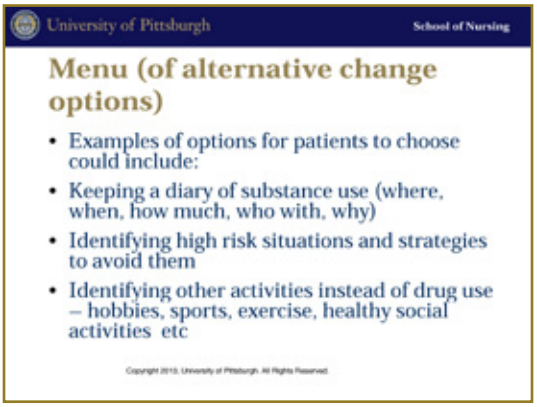


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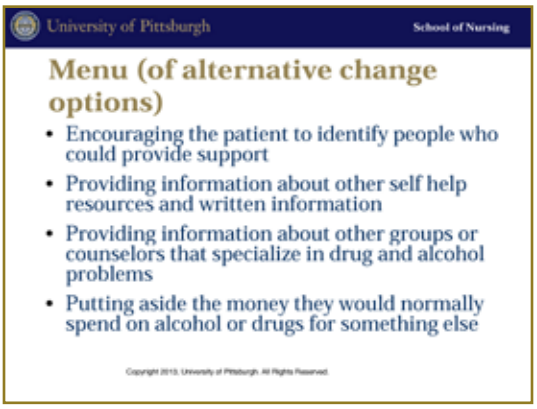


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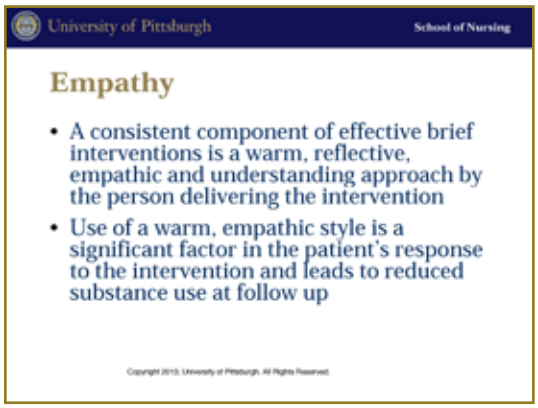


## 93. TRAINER NOTE:

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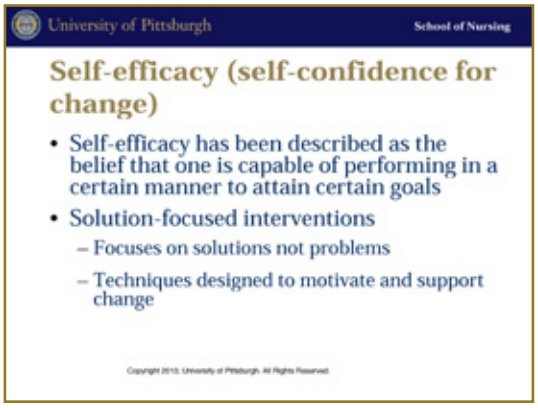



## 94. TRAINER NOTE:

Emphasize the importance of asking the patient if s/he is open to advice about behavior change before giving it.

Asking for permission demonstrates respect and allows the patient to have control, which helps to keep patients open to any suggestions that are made.


## 95. TRAINER NOTE:

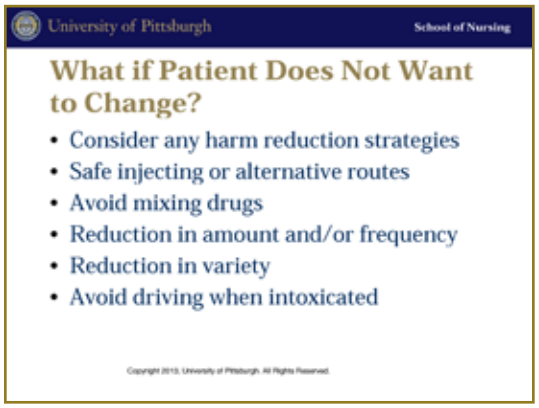
Small group activity: Introducing Alcohol Screening and Brief Intervention across Practice Settings (see the "Application scenarios" in the handout section).

Give each student the activity handout and break the students into small groups of 3 or 4 students (or larger, if necessary) each.

Assign each of the scenarios to a small group and ask the students as a group to discuss how they might introduce the issue of alcohol use when conducting a screening/brief. intervention. Ask them to identify how they might link current health problems to alcohol-related risks. Tell each group to identify a recorder who will report their group to the class when finished.

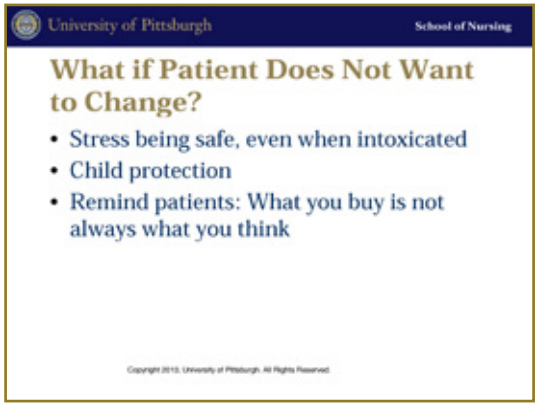
Allow 10 minutes for the groups to read and discuss their case study.

Ask each group to report their work, making any connections between substance use and patient's current health condition missed by the small group.

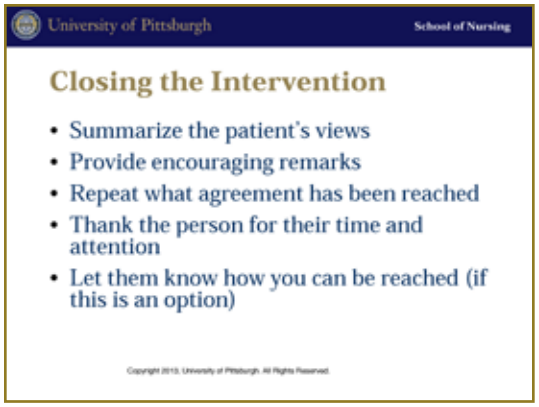



## 96. TRAINER NOTE:

After the small group activity, discuss "What if the patient does not want to change", using the bullets on this slide and the next one.




## 97. TRAINER NOTE:




## 98. TRAINER NOTE:

Discuss how to close the intervention and begin the Role Plays.

ROLE PLAYS

Tell students that they will now have an opportunity to role play discussing screening results with a patient using case studies from the previous exercise.

Ask them to form dyads and to decide who in each dyad will assume the role of patient or nurse.

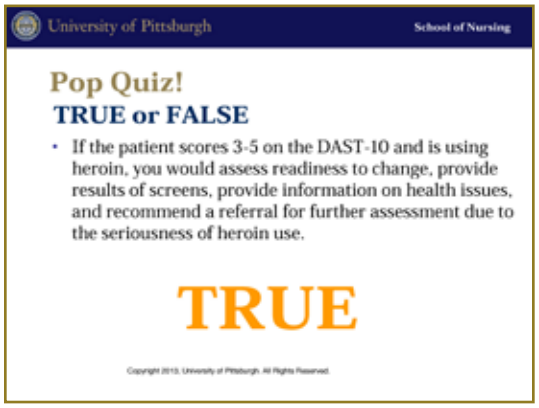
Tell the "nurses" that they have just conducted an alcohol screening with their patient and s/he has a score of 8 on the AUDIT.

Ask the "nurses" to discuss the screening results with the "patients" and link their results to the "patients'" current health problems.

Call time after 10 minutes.

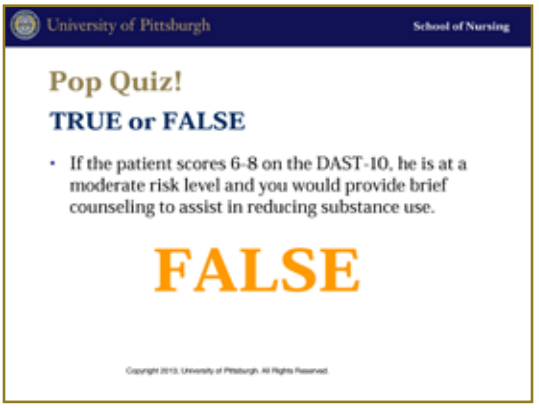
Ask "patients" what his or her nurse did particularly well during the role play.

Ask "nurses" if there was anyplace he or she got stuck during the role play.




## 99. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.




## 100. TRAINER NOTE:

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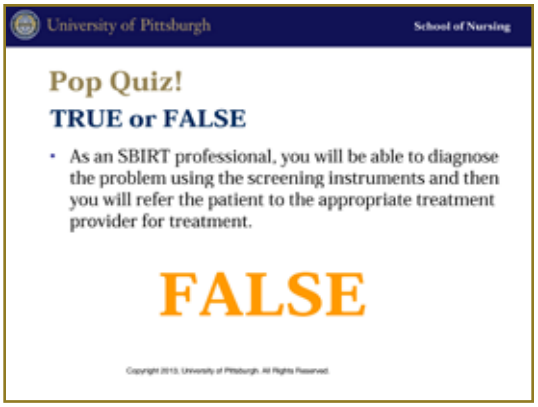


## 101. TRAINER NOTE:

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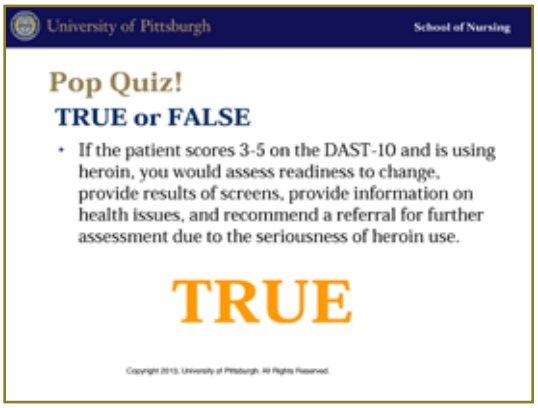
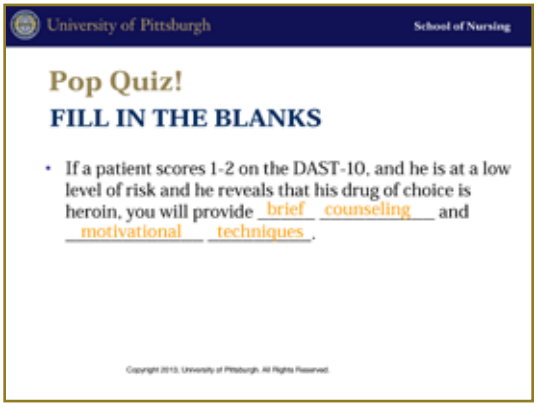


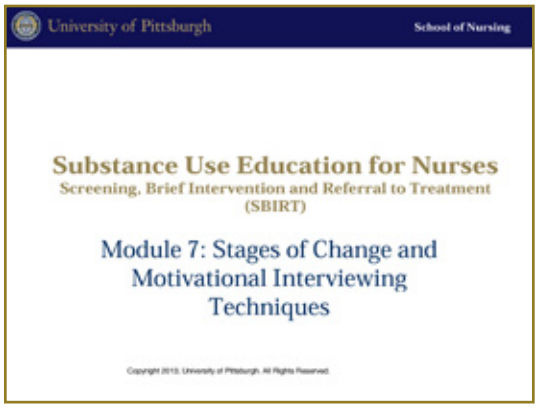

## 102. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.




## 103. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.




## 104. TRAINER NOTE:

This module introduces some of the concepts that provide the theoretical structure of the SBIRT model. It will help students to understand how people make decisions to change their behavior and how the healthcare provider can facilitate that process. It includes a discussion of some practical techniques to help patients make healthier choices.


## 105. TRAINER NOTE:

Small group activity—Getting in Touch with Your Own Risk

This is an exercise designed to get students in touch with their own health related risks and resistance to change.

**Use the following script for the exercise:**

Most of us engage in behaviors that pose some level of risk to our health and well-being. Looking at own risk-taking behavior and behavior change can reveal valuable insights into our work with patients. I am going to recite a list of behaviors that place people at risk.

*Mentally note which behaviors you engage in:*

- smoking cigarettes
- using alcohol or other drugs unwisely
- driving without seatbelts
- driving more than 15 miles above the speed limit
- engaging in unprotected vaginal, anal, or oral intercourse if not in a monogamous relationship
- being more than 25 pounds overweight
- failing to get cardiovascular exercise 3 times a week for at least 20 minutes a session
- failing to do regular breast/testicular self-exam
- being late for a pap smear, mammogram or prostate screening
- failing to follow medical advice about behavior changes
- riding a bicycle or motorcycle without a helmet
- Any other risky acts you think of

Select from the inventory the one risky behavior that has the most serious potential consequences.

Answer following questions to yourself: Why do I do this risky thing. What could someone say to me in a single intervention that would move me to change this behavior.

Now I am going to try to motivate you to make a behavior change. *At no time during this exercise will you be asked to reveal your risky behavior.* If you recognize your behavior has the potential to seriously harm your health stand up.

I have an actuarial table in front of me and it says people who do what you do will be dead in 10 years. You can avoid this 10 year outcome if you can honestly say you will stop/change this behavior as of this very moment. No negotiating or backsliding, it must be an absolute commitment to change.

## 105. CONTINUED:

If you can make this absolute commitment to change, you can sit down.

Doctors say that people who do what you do will be dead in 5 years. You can avoid this outcome if you can honestly.

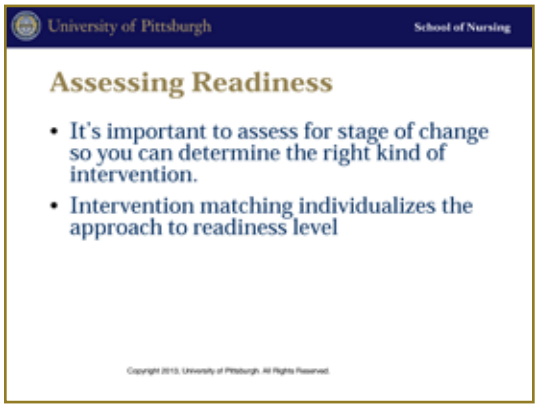
Those of you who can honestly commit to this sit down say you will stop/change this behavior as of this very moment. No negotiating or backsliding, it must be an absolute commitment to change. If you can make this absolute commitment to change, you can sit down.

Repeat for the following: 2 years, I year.

Process the exercise by asking the following:

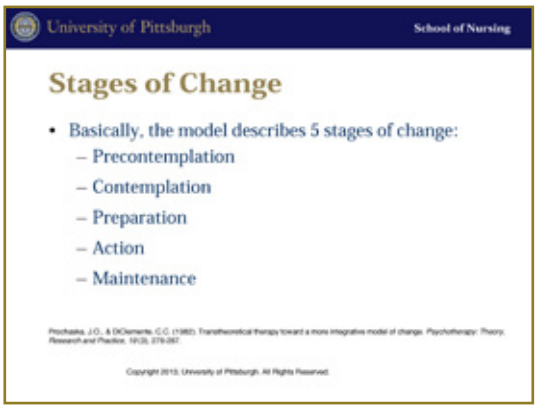
What did this exercise demonstrate?

How would they relate this exercise to their work with SBIRT?




## 106. TRAINER NOTE:

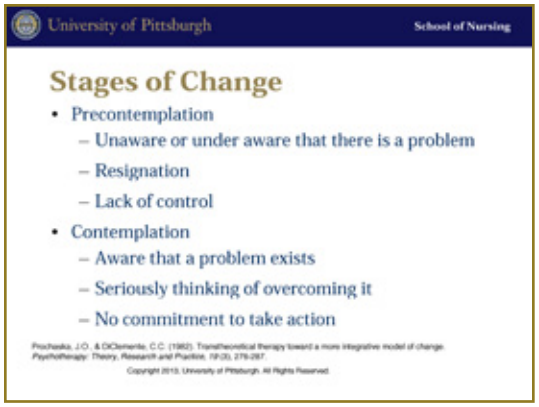
Determining how much behavior change a patient is willing, ready and able to make is an important step in the SBIRT process.




## 107. TRAINER NOTE:

The stages of change model is a roadmap for the change process. People move through this process at their own rate. We can guide and encourage change, but we can't force people to change more quickly than they want to.

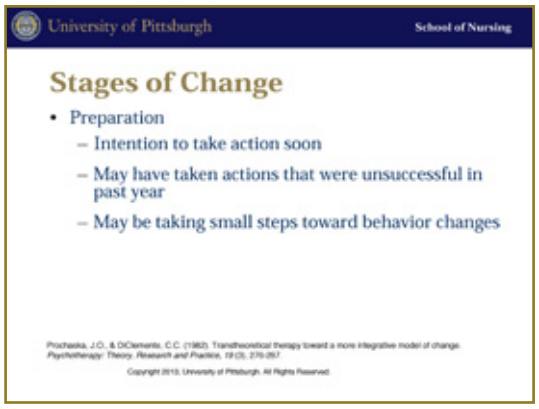
Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy toward a more integrative model of change. Psychotherapy: Theory, Research and Practice, 19(3), 276-287.




## 108. TRAINER NOTE:

Take time to discuss each stage of change using examples if possible.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy toward a more integrative model of change. Psychotherapy: Theory, Research and Practice, 19(3), 276-287.




## 109. TRAINER NOTE:

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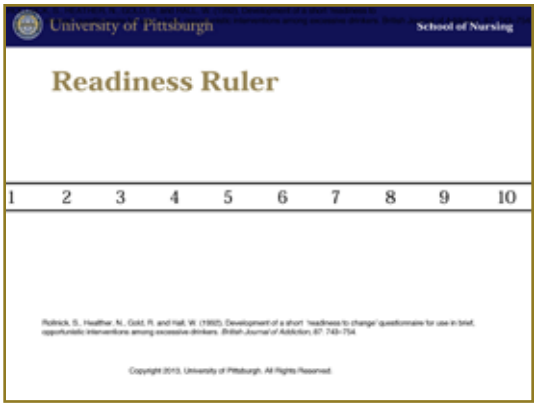
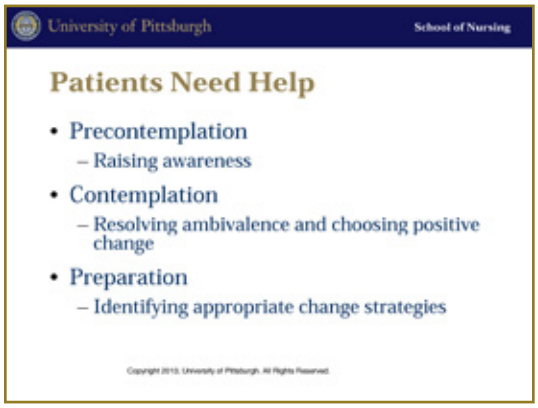


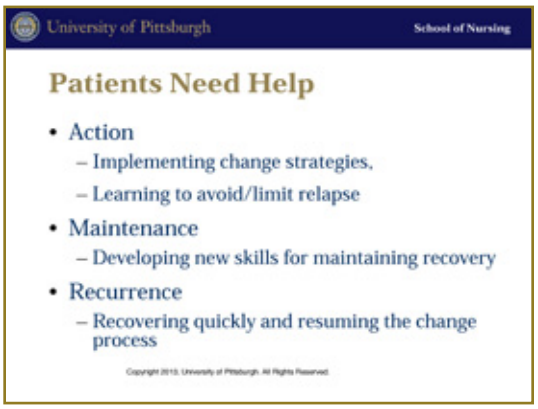

## 111. TRAINER NOTE:

Ask the patient to circle a number from 1 to 10 with 1 being not at all ready to change and 10 being very ready. When they circle a number, ask why they didn't circle a lower number, which invites them to talk about reasons to change. You can also ask "What would have to happen in order for you to circle a higher number?" This same ruler can be used to help the patient to determine how important making the change is and how confident they are that they can make the change.

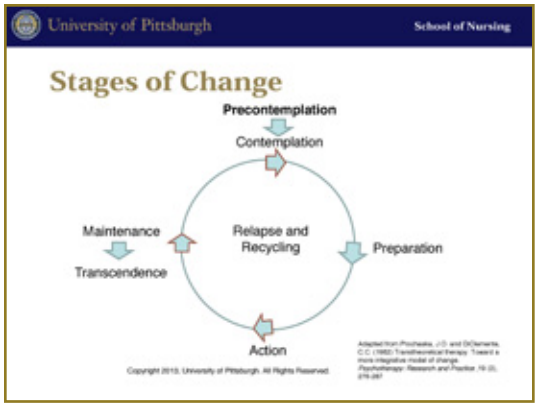
Rollnick, S., Healther, N., Gold, R. and Hall, W. (1992), Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive drinkers. British Journal of Addiction, 87: 743–754.




## 112. TRAINER NOTE:




## 113. TRAINER NOTE:



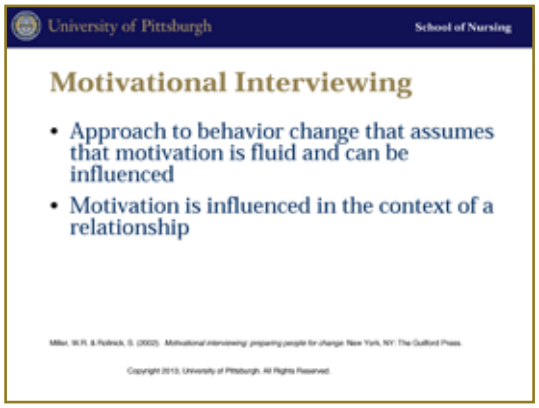

## 114. TRAINER NOTE:

Demonstrates the cyclical nature of behavior change.

Individuals move back and forth through the stages, only returning to precontemplation when they develop the belief that change is not possible.

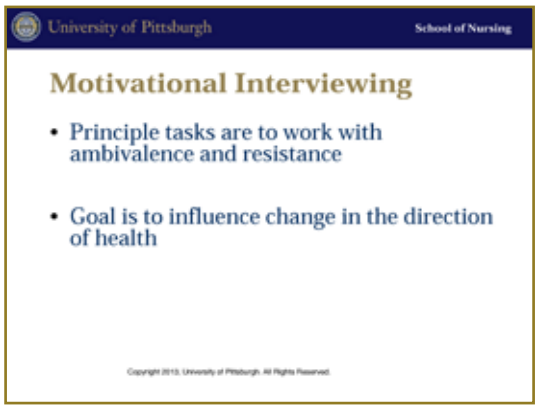
Some individuals make such significant changes in their life that a return to previous behavior is no longer probable and therefore transcend the behavior change cycle.

Adapted from Prochaska, J. O.and DiClemente, C. C. (1982) Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Research and Practice , 19 (3), 276-288

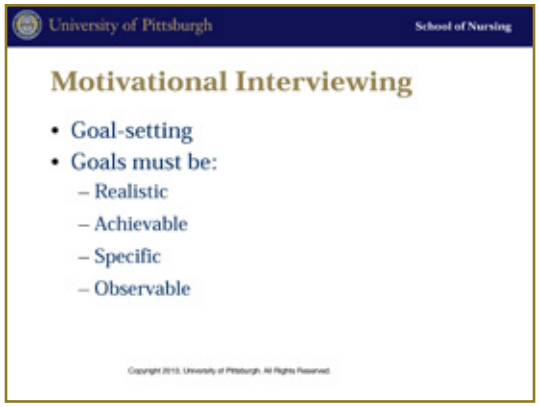



## 115. TRAINER NOTE:

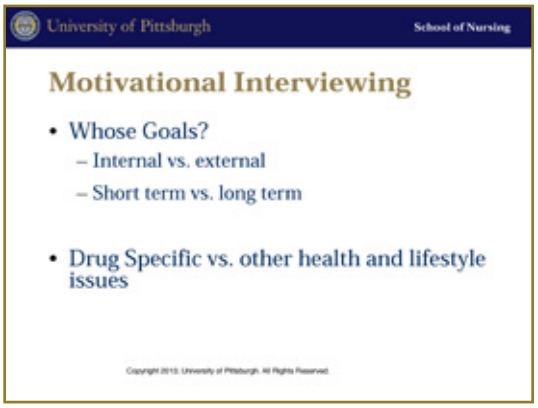
Miller, W. R. & Rollnick, S. (2002) Motivational Interviewing: Preparing people for change. New York, NY : The Guilford Press.



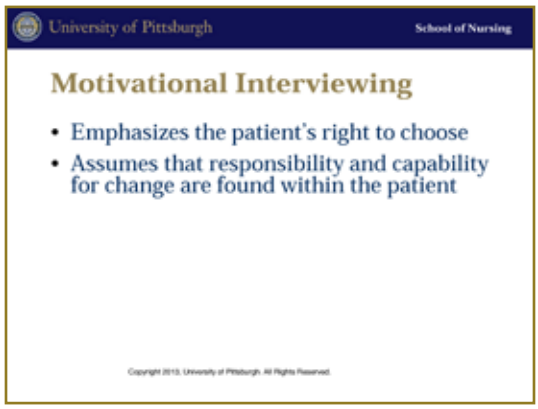

## 116. TRAINER NOTE:




**117.** **TRAINER NOTE:**




**118.** **TRAINER NOTE:**



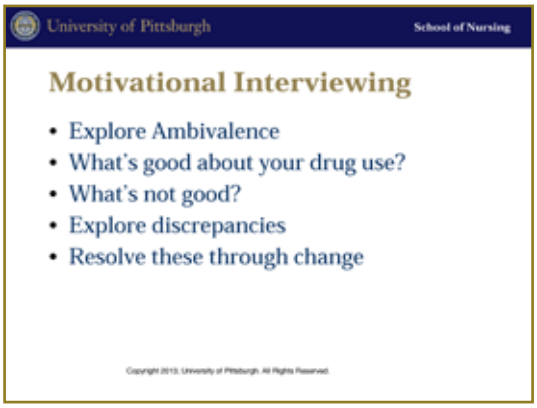

**119.** **TRAINER NOTE:**

Motivational Interviewing (MI) is a strengths-based approach to behavior change that believes that individual have capacity to make their own choices regarding change.


## 120. TRAINER NOTE:

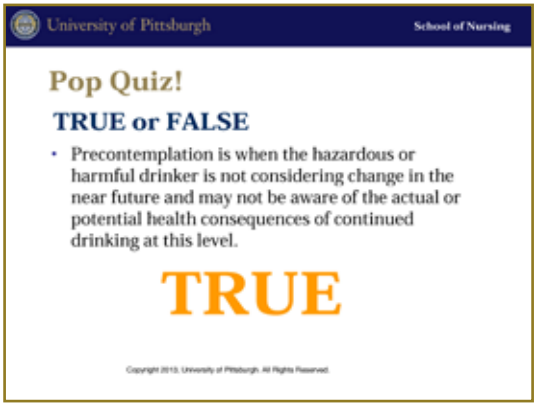
Motivational Interviewing (MI) is a strengths-based approach to behavior change that believes that individual have capacity to make Lists the core concepts of MI:

- Express Empathy
- Elicit ambivalence concerning the patient's current harmful behavior
- Elicit statements that reflect a desire to change
- Display effective counseling skills
- When met with resistance, change one's intervention own choices regarding change.



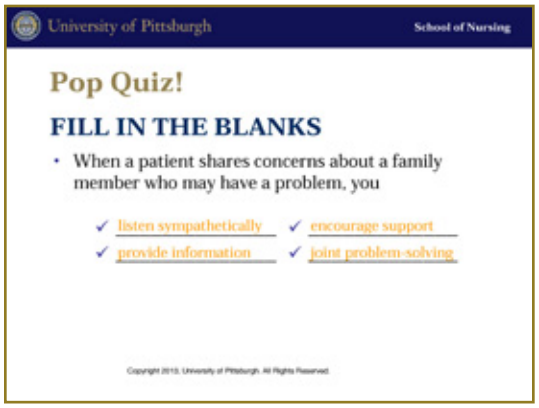

## 121. TRAINER NOTE:

Lists examples of effective questions to explore patient ambivalence.



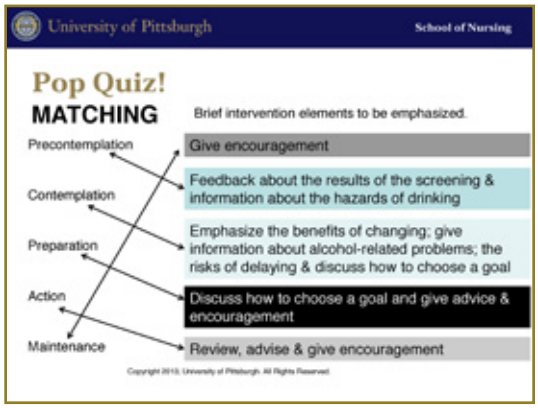

## 122. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.



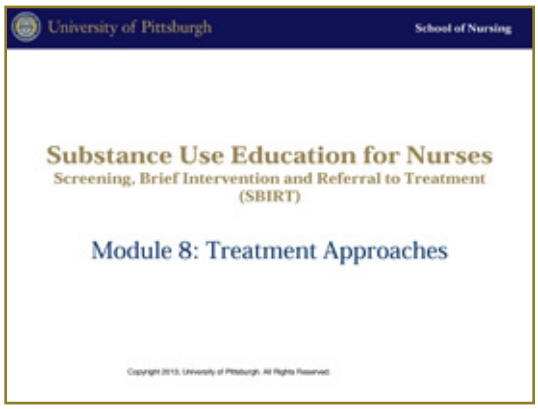

## 123. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.




## 124. TRAINER NOTE:

For this quiz, ask the students to take a minute to read the descriptions on the right had side of the slide, then ask which one goes with the Precontemplation stage of change. Then click and an arrow connecting Precontemplation with the correct answer will appear. Continue until all the stages of change are accounted for.



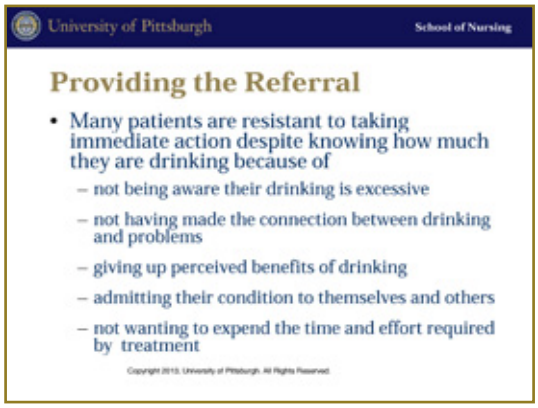

## 125. TRAINER NOTE:

This module will describe the different treatment approaches (levels of care) that are available, including abstinence based and pharmacologically assisted treatment. It also describes how to make a referral to treatment for those who may be in need of specialty care beyond a brief intervention. Some local resources for ongoing care are also presented.


## 126. TRAINER NOTE:

Lists the type of referrals patients might need:

- Detoxification, out-patient treatment, or residential treatment
- Integrated or concurrent treatment for mental health disorders
- Housing
- Self-help groups, therapists in private practice, or other types of community services

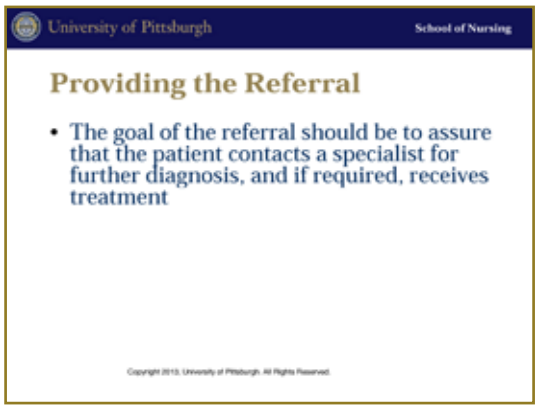



## 127. TRAINER NOTE:

Explains why patients might be resistant to follow through with a referral.

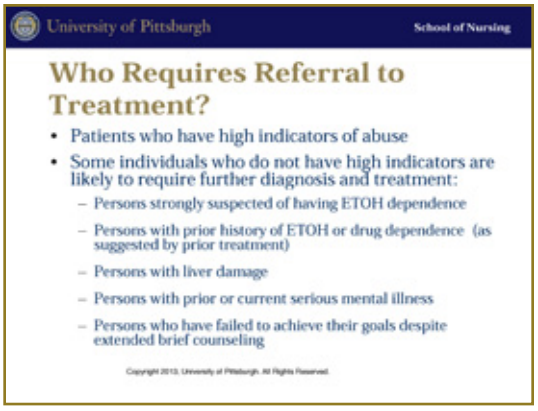
Highlight:

- Unaware or under aware that a problem exists
- Perceive the benefits of their behavior outweigh the costs
- Time, effort and money for treatment may be a barrier
- Previous negative experiences with treatment




## 128. TRAINER NOTE:

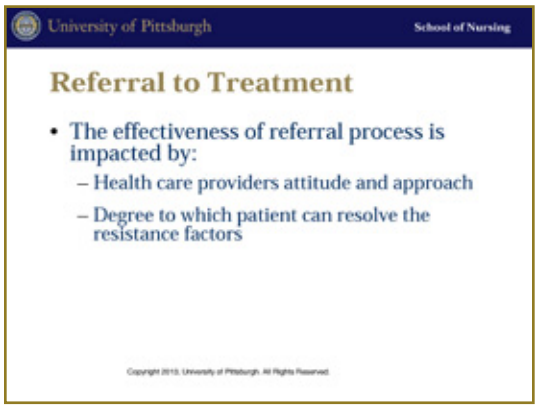
The goal is for patients to receive a diagnostic assessment and possible treatment




## 129. TRAINER NOTE:

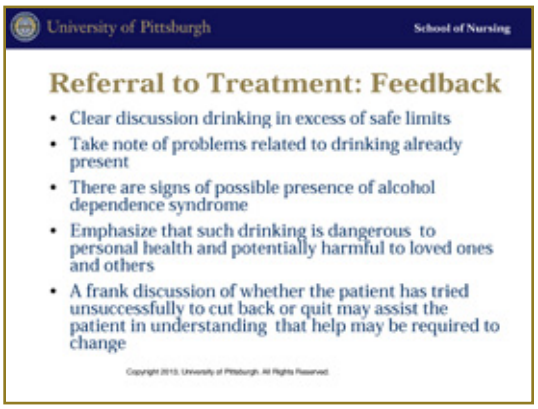
Patients with high indicators of abuse and those patients with other factors that suggest possible current abuse should receive a referral.

- History of alcohol or drug dependence
- Current or history of serious mental health disorder
- Liver damage
- Individuals who fail to achieve their goals despite extended counseling




## 130. TRAINER NOTE:

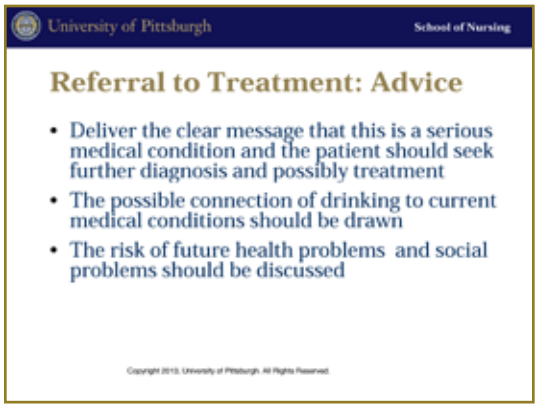
The health care providers attitude and approach as well as the degree of patient resistance determine the likelihood of follow through with a referral.




## 131. TRAINER NOTE:

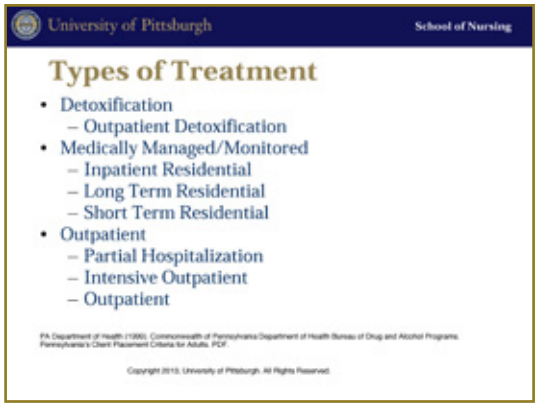
The health care providers attitude and approach as well as Reaffirm the significance of the screening results and their relevance to the patient's current health problems, their relationship to past, present and future harmful consequences.

Have a frank discussion with the patient concerning the need for behavior and his or her ability to change without help.




## 132. TRAINER NOTE:

Acknowledge the threat that the patient's current substance abuse presents to his or her health and well-being and the need to address this like any other health problem.




## 133. TRAINER NOTE:

**Detoxification** is the process whereby a drug or alcohol intoxicated or dependent patient is assisted through the period of time needed to eliminate (by metabolic or other means) the presence of the intoxicating substance or the dependency factors, while keeping the physiological or psychological risk to the patient at a minimum.

**Medically Managed Inpatient Residential** treatment provides 24-hour medically directed evaluation, care and treatment for addicted patients with coexisting biomedical, psychiatric and/or behavioral conditions which require frequent care. Facilities for such services need to have, at minimum, 24-hour nursing care, 24-hour access to specialize medical care and intensive medical care, and 2-hour access to physician care.

**Medically Monitored Long Term Residential** treatment is a type of service that includes 24-hour professionally directed evaluation, care, and treatment fro addicted patients in chronic distress, whose addiction symptomatolgy is demonstrated by severe impairment of social, occupational or school functioning.

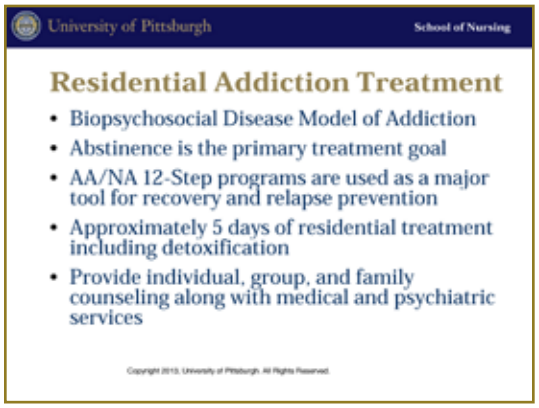
**Medically Monitored Short Term Residential** treatment is a type of service that includes 24-hour professionally directed evaluation, care and treatment for addicted patients in acute distress.

**Partial Hospitalization** treatment consists of the provision of psychiatric, psychological and other types of therapies on a planned and regularly scheduled basis in which the patient resides outside the facility. This service is designed for those patients who do not require 24-hour residential care but who would nontheless benefit from more intensive treatments than are offered in outpatient treatment projects.

**Intensive Outpatient** treatment is an organized, non-residential treatment service in which the patient resides outside the facility. The services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 day per week for at least 5 hours (but less than 10).

**Outpatient** treatment…provides psychotherapy… in regularly scheduled treatment sessions for at most 5 hours per week.

PA Department of Health (1999). Commonwealth of Pennsylvania Department of Health Bureau of Drug and Alcohol Programs. Pennsylvania's Client Placement Criteria for Adults. PDF.




## 134. TRAINER NOTE:

Residential chemical dependency treatment:

- Historically followed a disease model.
- Most programs include a biopsychosocial perspective.
- Abstinence based models that emphasize participation in 12-step groups which are often conducted on program premises.
- Provide medical, psychiatric and counseling services


## 135. TRAINER NOTE:

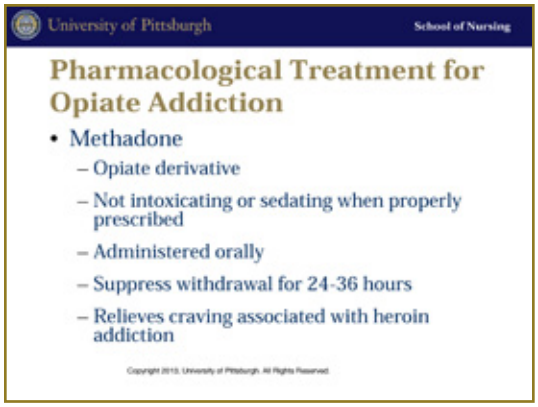
Drug Free Outpatient Treatment:

- Use a variety of treatment approaches.
- Vary in the length of treatment.


## 136. TRAINER NOTE:

Medically Assisted Treatment:

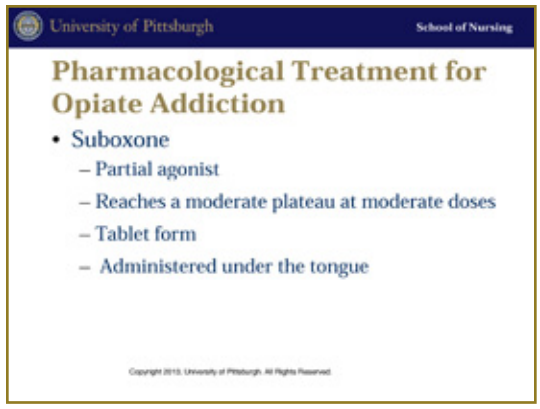
- Combines counseling with medication management of substance abuse.




## 137. TRAINER NOTE:

Medically Assisted Treatment:

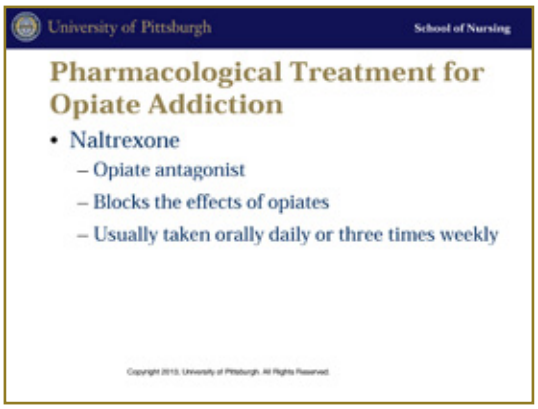
- Combines counseling with medication management of substance abuse.




## 138. TRAINER NOTE:

Medically Assisted Treatment:

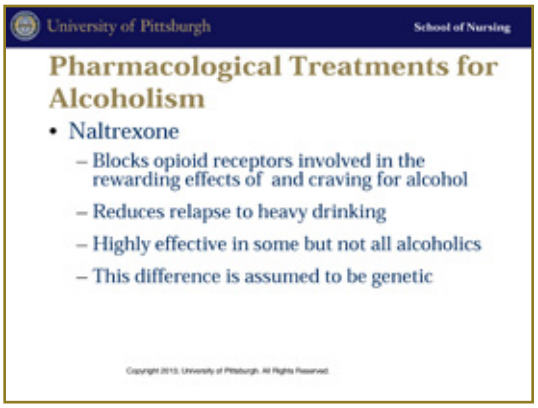
- Combines counseling with medication management of substance abuse




## 139. TRAINER NOTE:

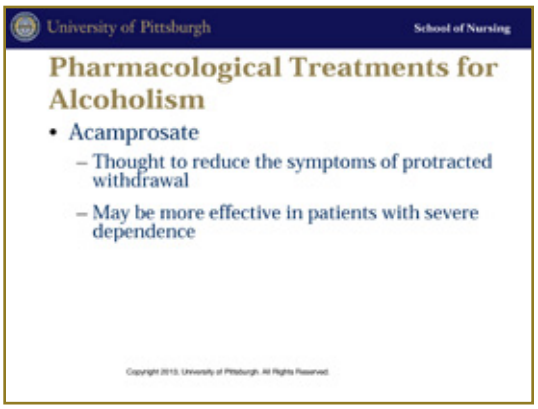
Naltrexone

- Opioid antagonist.
- Used in combination with treatment to prevent opiate drug use.
- Does not stop drug craving like methadone or suboxone.
- Research has demonstrated that it is effective when used with individuals highly motivated to change.




## 140. TRAINER NOTE:

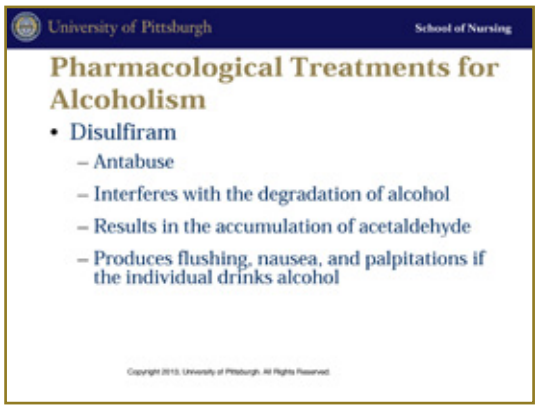
Naltrexone has been demonstrated to be very effective with some alcoholics who have long histories of chronic abuse.




## 141. TRAINER NOTE:

Acamprosate is used to manage alcohol withdrawal symptoms.

Does not stop drug craving.




## 142. TRAINER NOTE:

Describes the use of antabuse in alcohol treatment.


## 143. TRAINER NOTE:

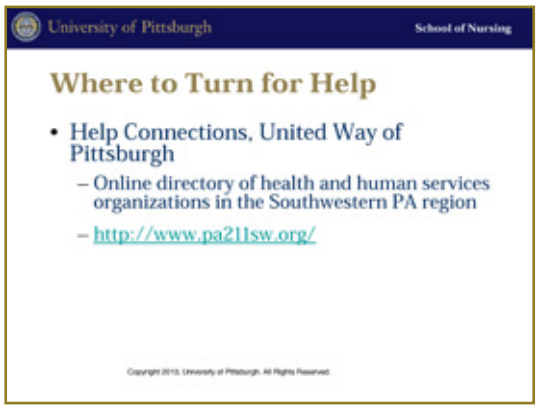
Therapeutic Communities:

- The most effective model of treatment for individuals who are addicted and have a long history of criminal behavior.
- Individuals who stay in TC for 90 days or more have better treatment outcomes than other treatment modalities.
- However these programs have high drop-out rates in the first 90 days.


## 144. TRAINER NOTE:

Web address for a directory of social services in Allegheny County.

Web address listing all the drug and alcohol treatment programs in Pennsylvania.




## 145. TRAINER NOTE:

Web address for a data bank listing all the social services in Western Pennsylvania.

Not very user friendly but provides a contact for assistance.


## 146. TRAINER NOTE:

Contact information for 12 Step self-help meetings for alcoholics and addicts in the Pittsburgh area.


## 147. TRAINER NOTE:

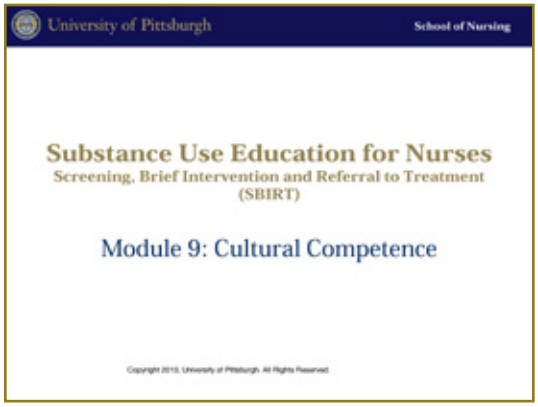
Contact information for 12 Step self-help meetings for alcoholics and addicts in the Pittsburgh area.


## 148. TRAINER NOTE:

Contact information for 12 Step self-help meetings for Contact information for Christian faith based self-help groups for addicts and their families.

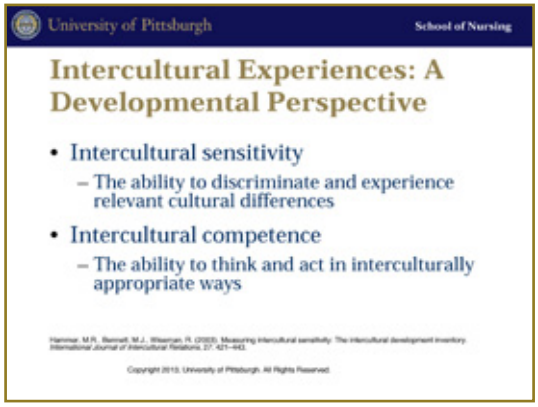

## 149. TRAINER NOTE:

Contact information for self-help programs that are not 12 Step based.



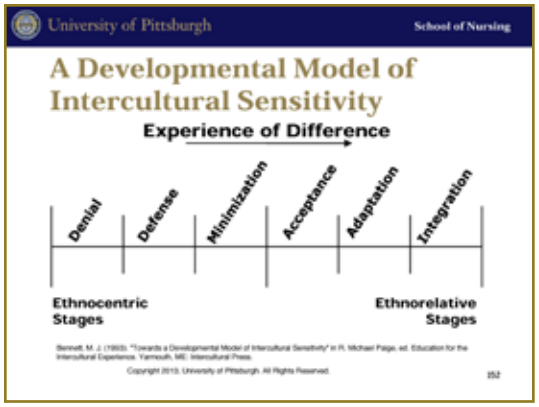

## 150. TRAINER NOTE:

Since cultural sensitivity is essential in providing good healthcare across the board, it is no different for SBIRT. This module discusses a developmental model of intercultural sensitivity and challenges the students to assess where they are in their abiltity to interact with patients in a culturally sensitive manner.



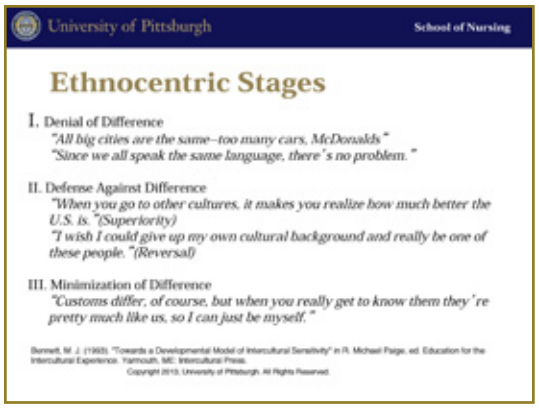

## 151. TRAINER NOTE:

Hammer, M.R., Bennett, M.J., Wiseman, R. (2003). Measuring intercultural sensitivity: The intercultural development inventory. International Journal of Intercultural Relations, 27: 421–443.



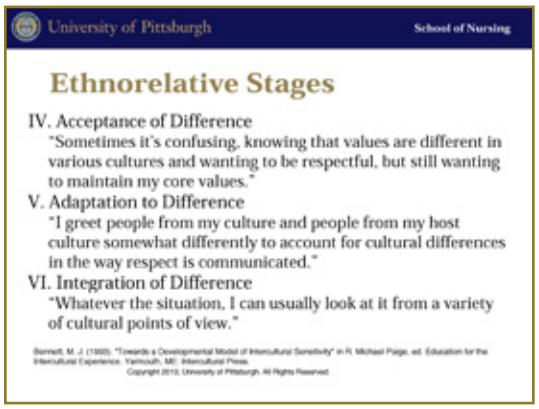

## 152. TRAINER NOTE:

Bennett, M. J. (1993). "Towards a Developmental Model of Intercultural Sensitivity" in R. Michael Paige, ed. Education for the Intercultural Experience. Yarmouth, ME: Intercultural Press.



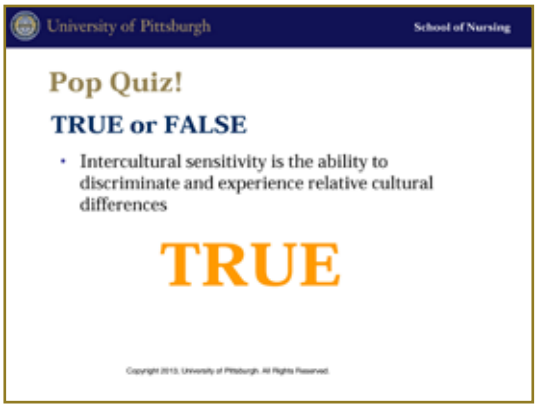

## 153. TRAINER NOTE:

Bennett, M. J. (1993). "Towards a Developmental Model of Intercultural Sensitivity" in R. Michael Paige, ed. Education for the Intercultural Experience. Yarmouth, ME: Intercultural Press.



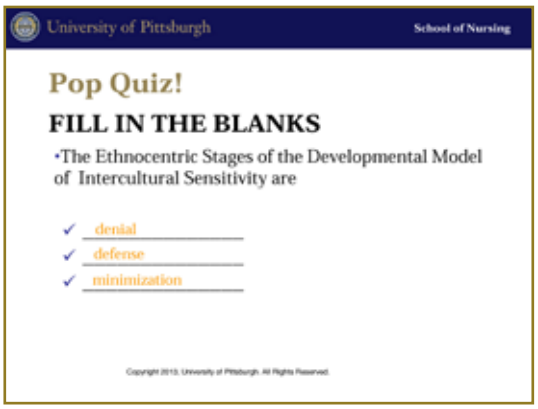

## 154. TRAINER NOTE:

Bennett, M. J. (1993). "Towards a Developmental Model of Intercultural Sensitivity" in R. Michael Paige, ed. Education for the Intercultural Experience. Yarmouth, ME: Intercultural Press.



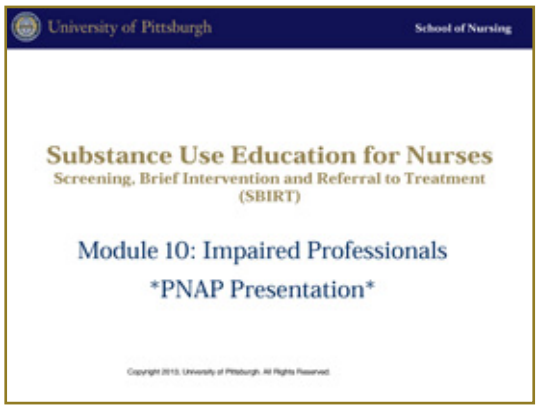

## 155. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.



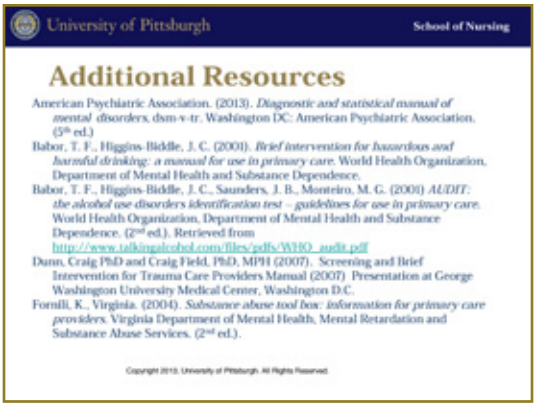

## 156. TRAINER NOTE:

For the "Pop Quiz" slides, the slide will first appear without the answers. Each click afterwards will then reveal the correct answers. The blanks will fill in one at a time.

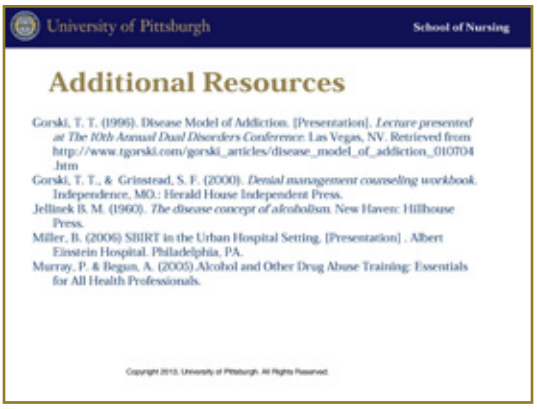



## 157. TRAINER NOTE:

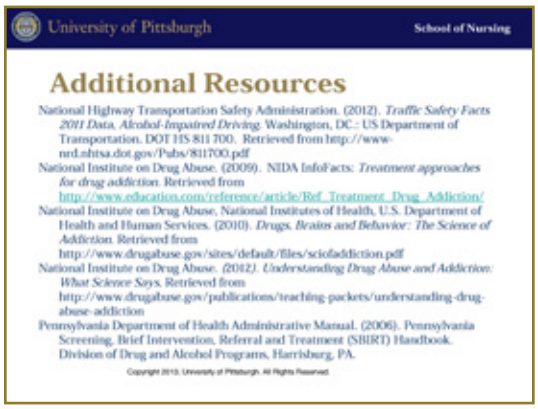
Direct students to the University of Pittsburgh's online learning platform to view this presentation.



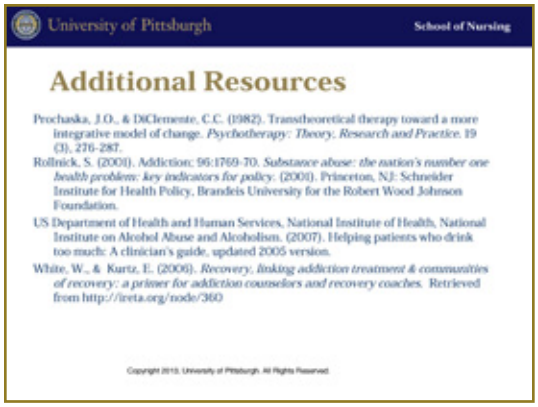

**158.** **TRAINER NOTE:**




**159.** **TRAINER NOTE:**




**160.** **TRAINER NOTE:**




**161.** **TRAINER NOTE:**

# SUBSTANCE USE EDUCATION FOR NURSES

# HANDOUTS

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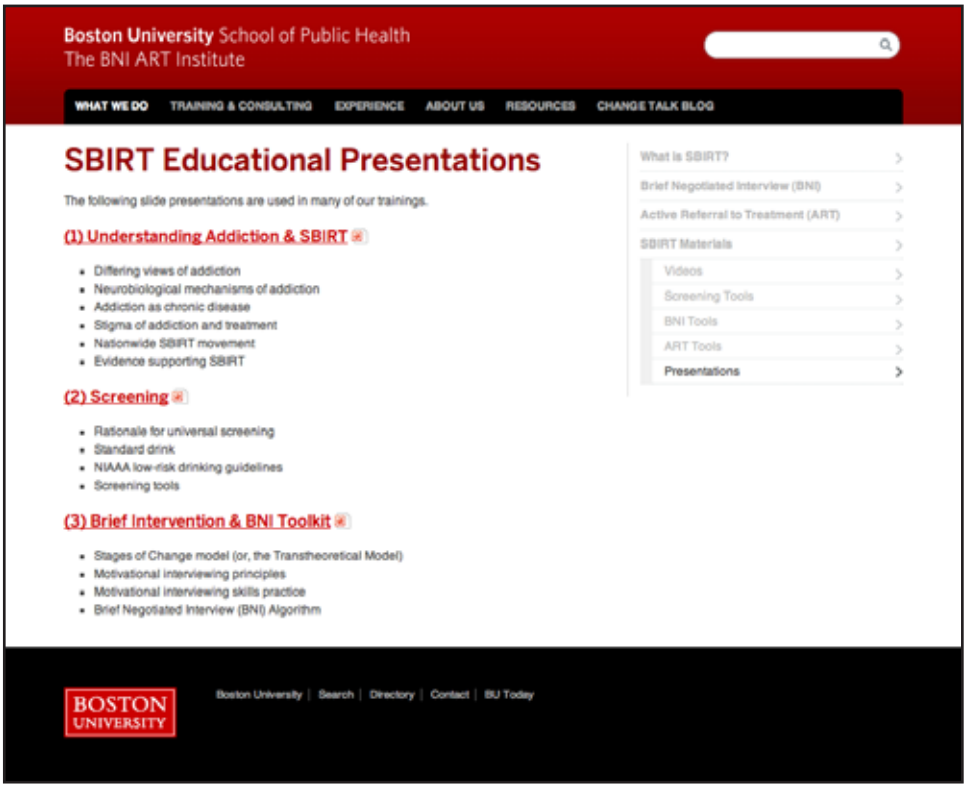
# INTRODUCING ALCOHOL SCREENING AND BRIEF INTERVENTION ACROSS PRACTICE SETTINGS

For small group exercises of case studies visit Boston University School of Public Health, The BNI ART Institute (2011). Introducing Alcohol Screening and Brief Intervention across Practice Settings.

Retrieved from http://www.bu.edu/bniart/sbirt-in-health-care/sbirt-educational-materials/sbirt-presentations/



**PATIENT:** Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

| Questions | 0 | 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times a month | 2 to 3 times a week | 4 or more times a week | |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more | |
| 3. How often do you have 5 or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | |
| | | | | | **Total** | |

***Note:*** This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.

Excerpted from NIH Publication No. 11–7805 | www.niaaa.nih.gov/YouthGuide

# SCREENING AND BRIEF INTERVENTION

Joan is a 36-year-old single mom with two children, ages 10 and 14. Joan works two jobs. One is full time one is part time. She shares custody of the children and their father has regular visitation with them every other weekend.

Joan presents at the neighborhood health clinic for a regular health exam. She is complaining of headaches, sleep difficulty. She has trouble falling asleep and wakes up frequently, particularly on the weekends. She says she feels tired all the time.

Joan admits that a couple of times a month, usually on the weekends when the kids are with their father, she goes out to the club with friends. She usually has 3-4 mixed drinks over the course of the evening. Once in a while she says she goes over her limit and comes home intoxicated. She said this has happened maybe twice in the last 6 months. She feels bad when this happens but says the drinking and socializing help her to "relax" once in a while and stop worrying about all her responsibilities.

She is proud to say she never misses work and she does not ever keep alcohol in the house since she does not want to get in the habit of drinking to relieve tension at home. Her Mom initially expressed some concern that she might be developing a bad routine drinking every other weekend and feared this might be the start of what could become a problem, but in the past year she has not said anything again because Joan's pattern of drinking as remained fairly steady.

Some Concerns for the Advice/BI Session:

- Present the test results – discuss the score and what it means in relationship to the continuum of alcohol use. You can use the scoring grid or just describe the test scores; you can also use the drinking pyramid. Ask what she thinks about the score.
- Drinking to handle anxiety and stress – what else is she doing to stress reduce?
- Discuss how alcohol can interfere with sleep issues.
- What is in the mixed drinks? Discuss a standard drink so she can accurately know what she is consuming. (Use the standard drink chart)
- Operating a vehicle when drinking – who is driving? Could mention times when it is not safe to drink at all
- Talk about the binge pattern – 4 or more for females
- Affirm her caution about not developing a routine of drinking at home to stress reduce and her decision to contain drinking to when her children are not with her.

# The AUDIT

**PATIENT:** Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

| Questions | 0 | 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|---|
| 1. How often do you have a drink containing alcohol? | Never | Monthly or less | 2 to 4 times a month | 2 to 3 times a week | 4 or more times a week | 2 |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more | 1 |
| 3. How often do you have 5 or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | 1 |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 5. How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 7. How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | 1 |
| 8. How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 9. Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| 10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year | 2 |
| | | | | | **Total** | 7 |

*Note:* This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.

Excerpted from NIH Publication No. 11–7805 | www.niaaa.nih.gov/YouthGuide

# SUBSTANCE USE EDUCATION FOR NURSES

# RING OF KNOWLEDGE CARDS

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# Substance Use Education for Nurses

## (SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT)

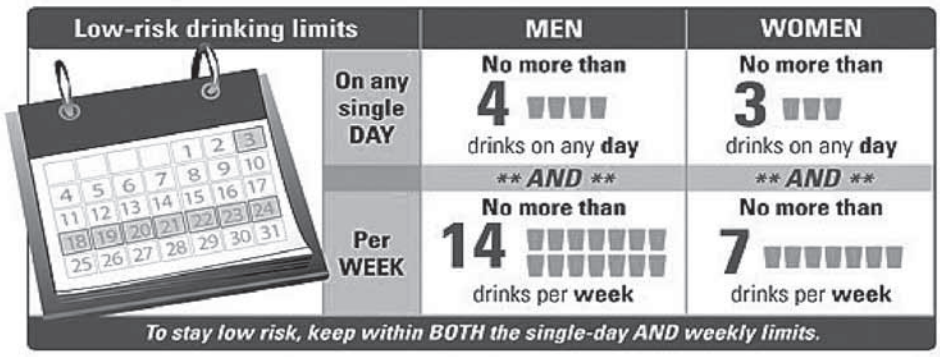
University of Pittsburgh
School of Nursing



This project was supported in part by funds from the Division of Nursing (DN), Bureaus of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under grant number D11HP14629. The information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by the Division of Nursing, BHPr, HRSA, DHHS or the U.S. Government. This material was created with the contributions of IRETA pursuant to a subaward from the University of Pittsburgh.

(11/2013)

## What's "low-risk" drinking?




National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking Drinking: Alcohol and your health (NIH Publication No. 10-3770)
www.rethinkingdrinking.niaaa.nih.gov

## What's "low-risk" drinking?

"Low risk" is not "no risk." Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older (**both men and women over 65 are generally advised to have no more than 3 drinks on any day and 7 per week**). Based on your health and how alcohol affects you, you may need to drink less or not at all. It's safest to avoid alcohol altogether if you are

- taking **medications** that interact with alcohol
- managing a **medical condition** that can be made worse by drinking
- **underage**
- planning to **drive** a vehicle or operate machinery
- **pregnant** or trying to become pregnant

National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking Drinking: Alcohol and your health (NIH Publication No. 10-3770) www.rethinkingdrinking.niaaa.nih.gov

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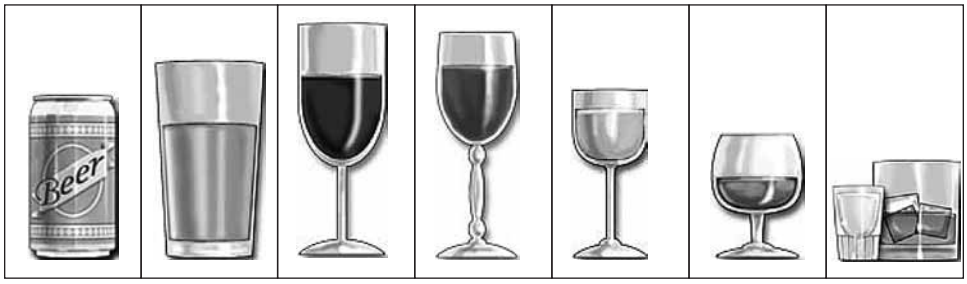
## What's a Standard Drink?

*Although the drinks below are different sizes, each contains approximately the same amount of alcohol and counts as a single standard drink*

| 12 fl oz of **regular beer** | = | 8-9 fl oz of **malt liquor** | = | 5 fl oz of **table wine** | = | 3-4 oz of **fortified wine** (sherry, port etc.) | = | 2-3 oz of **cordial, liqueur, or aperitif** | = | 1.5 oz of **brandy** (1 jigger or shot) | = | 1.5 fl oz shot of **80-proof spirits** ("hard liquor") |
|---|---|---|---|---|---|---|---|---|---|---|---|---|




| about 5% alcohol | about 7% alcohol | about 12% alcohol | about 17% alcohol | about 24% alcohol | about 40% alcohol | about 40% alcohol |
|---|---|---|---|---|---|---|

National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking Drinking: Alcohol and your health (NIH Publication No. 10-3770) www.rethinkingdrinking.niaaa.nih.gov

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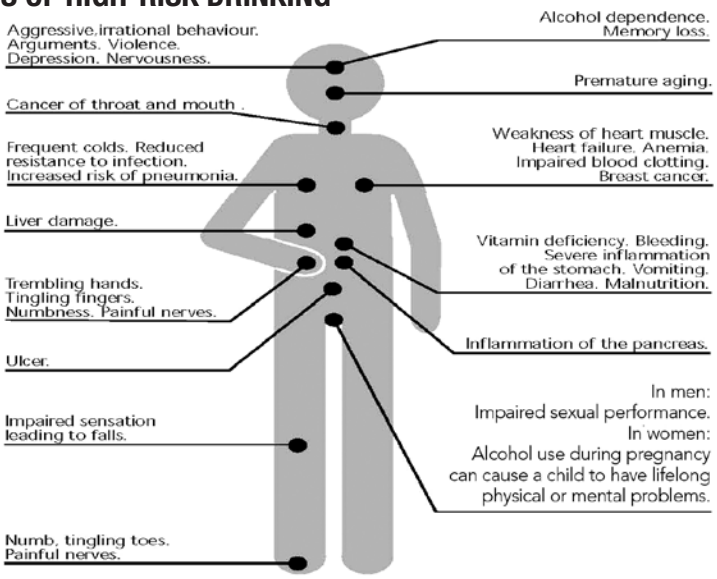
## EFFECTS OF HIGH-RISK DRINKING




*High-risk drinking may lead to social, legal, medical, domestic, job and financial problems. It may also cut your lifespan and lead to accidents and death from drunken driving.*

Adapted from: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.

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## Alcohol Pre-Screen:

**How many times in the past year have you had X or more drinks in a day?**

*(X equals 5 for men and 4 for women). Reporting 1 or more occurrences of this is considered a positive result and should trigger more in-depth screening and possibly a brief intervention.*

National Institute on Alcohol Abuse and Alcoholism. (2007). *Helping Patients Who Drink Too Much: A Clinician's Guide* (NIH Publication No. 07-3769)

## Drug Pre-Screen:

**How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?**

*A score of 1 or more is considered a positive result and should trigger more in-depth screening and possibly a brief intervention.*

National Institute on Drug Abuse. (2011). *Screening for Drug Use in General Medical Settings: Quick Reference Guide* (NIH Publication No. 11-7384)

## Tobacco Pre-Screen:

**Do you currently smoke or use any form of tobacco?**

*Yes = a positive screen and should trigger more in-depth screening and possibly a brief intervention.*

Fiore MC, Bailey WC, Cohen SJ, et. al. *Treating Tobacco Use and Dependence. Quick Reference Guide for Clinicians.* Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. October 2000

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## 3 QUESTION AUDIT

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

| **1. How often do you have a drink containing alcohol?** | | **2. How many drinks containing alcohol do you have on a typical day when you are drinking?** | | **3. How often do you have five or more drinks on one occasion?** | |
|---|---|---|---|---|---|
| Never | 0 | 1 or 2 drinks | 0 | Never | 0 |
| Monthly or less | 1 | 3 or 4 drinks | 1 | Less than monthly | 1 |
| 2 - 4 times a month | 2 | 5 or 6 drinks | 2 | Monthly | 2 |
| 2 - 3 times a week | 3 | 7 to 9 drinks | 3 | Weekly | 3 |
| 4 or more times a week | 4 | 10 or more | 4 | Daily or almost daily | 4 |

Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.

To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org. Excerpted from NIH Publication No. 11–7805 | www.niaaa.nih.gov/YouthGuide




## FULL AUDIT: SELF-REPORT VERSION (FOLLOWING TWO PAGES)

*PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.*

| Questions | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **1.** How often do you have a drink containing alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| **2.** How many drinks containing alcohol do you have on a typical day when you are drinking? | 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |
| **3.** How often do you have five or more drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **4.** How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **5.** How often during the last year have you failed to do what was normally expected of you because of drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

| Questions | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **6.** How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **7.** How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **8.** How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| **9.** Have you or someone else been injured because of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year |
| **10.** Has a relative, friend, doctor, or other healthcare worker been concerned about your drinking or suggested you cut down? | No | | Yes, but not in the last year | | Yes, during the last year |
| **TOTAL** | | | | | |

Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.

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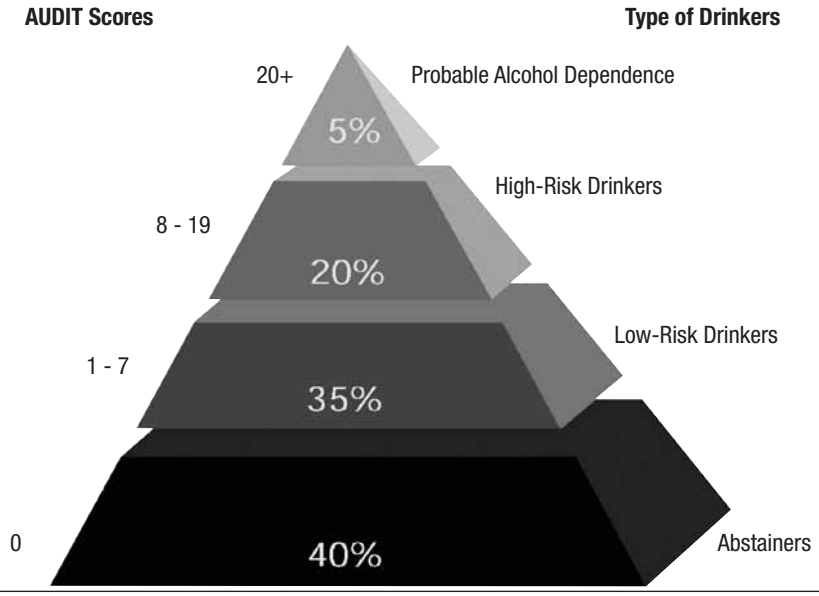
## AUDIT SCORING

| Score | Suggested Action |
|---|---|
| 0-7 | Alcohol Education |
| 8-15 | Simple Advice |
| 16-19 | Simple Advice plus Brief Counseling and Continued Monitoring |
| 20-40 | Referral to Specialist for Diagnostic Evaluation and Treatment |

Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.

## THE DRINKERS PYRAMID




Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.




## DRUG ABUSE SCREENING TEST- DAST-10

These Questions Refer to the Past 12 Months

| | | | |
|---|---|---|---|
| 1. | Have you used drugs other than those required for medical reasons? | ❑ Yes | ❑ No |
| 2. | Do you abuse more than one drug at a time? | ❑ Yes | ❑ No |
| 3. | Are you unable to stop using drugs when you want to? | ❑ Yes | ❑ No |
| 4. | Have you ever had blackouts or flashbacks as a result of drug use? | ❑ Yes | ❑ No |
| 5. | Do you ever feel bad or guilty about your drug use? | ❑ Yes | ❑ No |
| 6. | Does your spouse (or parents) ever complain about your involvement with drugs? | ❑ Yes | ❑ No |
| 7. | Have you neglected your family because of your use of drugs? | ❑ Yes | ❑ No |
| 8. | Have you engaged in illegal activities in order to obtain drugs? | ❑ Yes | ❑ No |
| 9. | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | ❑ Yes | ❑ No |
| 10. | Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)? | ❑ Yes | ❑ No |
| | **TOTAL:** | _____ | _____ |

Gavin D.R., Ross H.E., Skinner H.A. (1989). Diagnostic validity of the drug abuse screening test in the assessment of dsm-iii drug disorders. *British Journal of Addiction* 84(3), 301-307.

## DAST SCORING

DAST-10 Interpretation (Each "Yes" response = 1)

| SCORE | DEGREE OF PROBLEMS RELATED TO DRUG ABUSE | SUGGESTED ACTION |
|---|---|---|
| 0 | No Problems Reported | Encouragement & education |
| 1-2 | Low Level | Risky Behavior- Feedback & Advice |
| 3-5 | Moderate Level | Harmful Behavior- Feedback & Counseling; Possible referral for specialized assessment |
| 6-8 | Substantial Level | Intensive Assessment and referral |
| 9-10 | Severe Level | Intensive Assessment and referral |

Gavin D.R., Ross H.E., Skinner H.A. (1989). Diagnostic validity of the drug abuse screening test in the assessment of dsm-iii drug disorders. *British Journal of Addiction* 84(3), 301-307.




## CAGE-Adapted to Include Drugs (CAGE-AID)

1. Have you ever felt you should **CUT** down on your drinking or drug use?
   Drinking: YES _____ NO _____
   Drug Use: YES _____ NO _____
2. Have people **ANNOYED** you by criticizing your drinking or drug use?
   Drinking: YES _____ NO _____
   Drug Use: YES _____ NO _____
3. Have you ever felt bad or **GUILTY** about your drinking or drug use?
   Drinking: YES _____ NO _____
   Drug Use: YES _____ NO _____
4. Have you ever had an **EYE OPENER** (a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover)?
   Drinking: YES _____ NO _____
   Drug Use: YES _____ NO _____

**Scoring: Regard one or more "yes" responses to the CAGE-AID as a positive screen.**

Brown, R.L., & Rounds, L.A. (1995). Conjoint screening questionnaires for alcohol and drug abuse. Wisconsin Medical Journal 94:135-140

## TACE

TACE was designed for use in obstetric settings to identify women who are at-risk drinkers.

**T**olerance: "How many drinks does it take to make you feel high?"
(More than 2 drinks = 2 points)

**A**nnoyed: "Have people annoyed you by criticizing your drinking?"
(Positive response = 1 point)

**C**ut down: "Have you ever felt that you ought to cut down on your drinking?"
(Positive response = 1 point)

**E**ye opener: "Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?" (Positive response = 1 point)

*Any score of 2 total points or higher on the TACE survey indicates a positive screen for at-risk drinking.*

Sokol, R.J., Martier, S.S., Ager, J.W. (1989). The T-ACE questions: Practical prenatal detection of risk-drinking. *American Journal of Obstetrics and Gynecology* 160(4), 863-870.




## Fagerstrom Test for Nicotine Dependence *

Is smoking "just a habit" or are you addicted? Take this test and find out your level of dependence on nicotine.

1. How soon after you wake up do you smoke your first cigarette?
- After 60 minutes (0)
- 31-60 minutes (1)
- 6-30 minutes (2)
- Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?
- No (0)
- Yes (1)

3. Which cigarette would you hate most to give up?
- The first in the morning (1)
- Any other (0)

4. How many cigarettes per day do you smoke?
- 10 or less (0)
- 11-20 (1)
- 21-30 (2)
- 31 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?
- No (0)
- Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?
- No (0)
- Yes (1)

Your score was:_____. Your level of dependence on nicotine is:

**0-2:** very low dependence
**3-4:** low dependence
**5:** Medium dependence
**6-7:** high dependence
**8-10:** very high dependence

**Scores under 5:** Your level of nicotine dependence is still low. You should act now before your level of dependence increases.

**Score of 5:** Your level of nicotine dependence is moderate. If you don't quit soon, your level of dependence on nicotine will increase until you may be seriously addicted. Act now to end your dependence on nicotine.

**Score over 7:** Your level of dependence is high. You aren't in control of your smoking – it is in control of you! When you make the decision to quit, you may want to talk with your doctor about nicotine replacement therapy or other medications to help you break your addiction.

REFERENCES FOR PAGES 19-20: * Heatherton, T.F., Kozlowski, L.T., Frecker, R.C., Fagerstrom, K.O. (1991). The fagerstrom test for nicotine dependence: A revision of the fagerstrom tolerance questionnaire. *British Journal of Addictions*, 86, 1119-27.




## Stages of Change

1. Relevant to changing a wide range of health-related behaviors
2. Predictable sequence of stages (attitudes, intentions, behaviors)
3. Non-linear pattern of progress typical

### BASICALLY, THE MODEL DESCRIBES 5 STAGES OF CHANGE:

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*(3), 276-287.

## Job of Brief Interventions:

- **Raise the Subject:** "If it's okay with you, let's take a minute to talk about the screening questions you answered today."
- **Provide Feedback:** "I can tell you that drinking (drug use) at this level can be harmful to your health and possibly responsible for the health problem you came in for today (and/or may interact in a harmful way with your medication)."
- **Enhance Motivation:** "On a scale of 0-10, how ready are you to cut back your use?"
    - If >0: "Why that number and not a _ (lower number)
    - If 0: "Have you ever done anything while drinking (using drugs) that you later regretted?
- **Negotiate Plan:** "What steps can you take to cut back your use?"

  "How would your drinking (drug use) have to impact your life in order for you to start thinking about quitting or cutting back?"

Oregon Health and Science University, 2012 http://www.sbirtoregon.org/resources/Readiness%20ruler%20-%20English.pdf

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## Components of Brief Interventions: The FRAMES Model

**F**eedback
**R**esponsibility
**A**dvice
**M**enu of options
**E**mpathy
**S**elf efficacy

Rollnick S., & Miller, W.R. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy,* 23, 325-334.

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## FLO: The 3 Tasks of a Brief Intervention

**F**eedback

**L**isten and Understand

**O**ptions Explored

Dunn, C.W., Huber, A., Estee, S., Krupski, A., O'Neill, S., Malmer, D., & Ries, R. (2010). *Screening, brief intervention, and referral to treatment for substance abuse: A training manual for acute medical settings.* Olympia, WA: Department of Social and Health Services, Division of Behavioral Health and Recovery

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## READINESS RULER

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

ROLLNICK, S., HEATHER, N., GOLD, R. and HALL, W. (1992), Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive drinkers. British Journal of Addiction, 87: 743–754. doi: 10.1111/j.1360-0443.1992.tb02720.x

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## Where to Turn Resources

Allegheny County: Where to Call – Directory of Mental Health and Drug and Alcohol Services: http://www.alleghenycounty.us/dhs/substanceabuse.aspx

Help Connections, United Way of Pittsburgh. Online directory of health and human services organizations in the Southwestern PA region: http://www.unitedwaypittsburgh.org/HelpConnections.aspx?id=284

Alcoholics Anonymous / 12 -Step self help group for alcoholics: 412-471-7420; http://www.pghaa.org

Narcotics Anonymous / 12-Step self help group for drug addicts: 412-391-5247; www.tristate-na.org

Al-Anon/Alateen / 12- Step support groups for families of alcoholics: 1-888-425-2666; http://www.pa-al-anon.org

NAR Anon / 12-Step support groups for families of drug addicts: 412-782-2210

Celebrate Recovery, Christian faith-based support groups for alcoholics and drug addicts, www.celebraterecovery.com/cr-groups

Reference: Online resources (2009) complied from The ATN-SBIRT Program, a partnership with the University of Pittsburgh, School of Nursing and IRETA supported by Grant D11HP14629 from the Division of Nursing and the Office of Health Information Technology, Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS)




ireta

Institute for Research, Education and Training in Addictions

# SUBSTANCE USE EDUCATION FOR NURSES SENIOR COURSE

## KEY TO ICONS

**The icon above relates to additional instructions for the trainer.**

**The icon above relates to activities for the group.**

**The icon above relates to additional reference material provided by the trainer.**

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**1. TRAINER NOTE:**


**2. TRAINER NOTE:**


**3. TRAINER NOTE:**

Materials: Copies of journal articles and worksheets.

Break the participants into groups of 3.

Assign one of the handouts to each group and give each group member a copy of the handout and each group a copy of the worksheet.

Instruct the participants to read and review the handout.

Once each participant in the group has done so, ask the participants to discuss as a group the main topic of their handout.

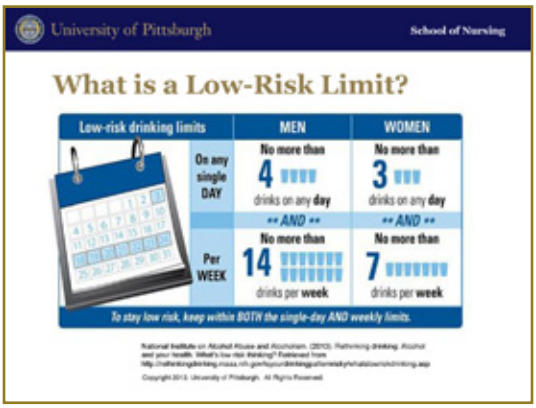
Each group should identify a recorder for the group who will complete the group worksheet and a reporter who will share the small group's completed work with the larger group.

Have each group's reporter share an overview of his or her group's topic.


## 4. TRAINER NOTE:

Remind students that SBIRT can address all levels of the pyramid, people who screen negative (the bottom 2 levels) encouragement. If "safe drinkers" fall into a category where they need to refrain from alcohol use (e.g. pregnant women, people on certain medications or with certain medical conditions), share that information and encourage them to stop drinking altogether. People who screen positive (top 3 levels) should be given appropriate information, brief interventions or a referral for further assessment or treatment.

Gentilello, L. (2009). Alcohol Screening and Intervention: ... The Trauma Surgery Perspective [PowerPoint slides]. Retrieved from www.wiphl.com/uploads/media/Gentilello_Trauma_Slides_10.06.09.ppt




## 5. TRAINER NOTE:

A low risk limit is no more than 2 standard drinks per day and no drinking on at least two days during the week.

National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking drinking: Alcohol and your health. What's low-risk thinking? Retrieved from http://rethinkingdrinking.niaaa.nih.gov/isyourdrinkingpatternrisky/whatslowriskdrinking.asp


## 6. TRAINER NOTE:

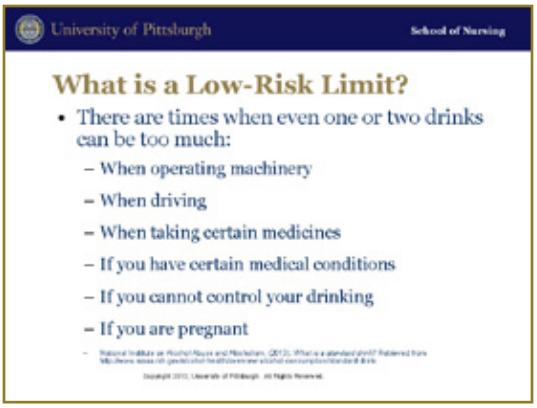
National Institute on Alcohol Abuse and Alcoholism. (2013). Rethinking drinking: Alcohol and your health. What's low-risk thinking? Retrieved from http://rethinkingdrinking.niaaa.nih.gov/isyourdrinkingpatternrisky/whatslowriskdrinking.asp

Remind students that this at-risk level identifies the levels of alcohol consumption that can exacerbate or precipitate health problems in the elderly population.

Low-risk limits are based upon how a standard drink is defined: 1.5 oz. of alcohol.

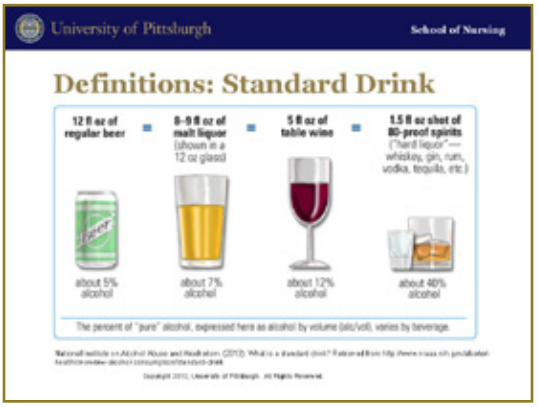
Remind students of the importance, when conducting a screen, to ask an individual what a standard drink of alcohol may be for him or for her.

A drink for an individual could be double or triple the amount usually in a standard drink.



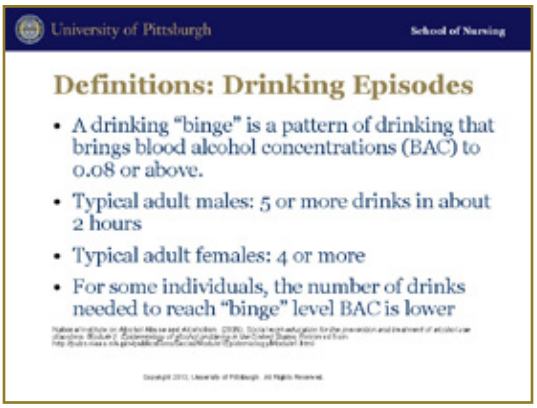

## 7. TRAINER NOTE:

Acknowledge that there are some situations, like those listed on this slide, when individuals should avoid any alcohol consumption. See if the students have suggestions for others.




## 8. TRAINER NOTE:

National Institute on Alcohol Abuse and Alcoholism. (2013). What is a standard drink? Retrieved from http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/standard-drink




## 9. TRAINER NOTE:

It is important to recognize that for some individuals, harmful drinking may only occur on one or two occasions during the month or year. Even though infrequent, this type of alcohol consumption can have significant harmful consequences for an individual's health and well-being.

In February, 2004 the National Institute on Alcohol Abuse and Alcoholism (NIAAA) Advisory Council Task Force issued recommendations regarding the definition of "binge drinking." This definition is not dependent on the number of drinks consumed, nor is it related to the time frame of drinking session. It is based on drinking behaviors that raise an individual's blood alcohol concentration (BAC) up to or above the level of 0.08 gm%. This is typically reached for men with 5 or more drinks in about 2 hours, and for women with 4 or more drinks.

In the above definition, a "drink" refers to half an ounce of alcohol (e.g., one 12 oz. beer, one 5 oz. glass of wine, one 1 ½ oz. shot of distilled spirits).

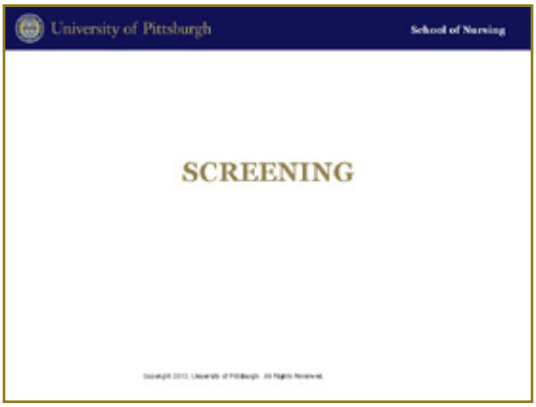
Binge drinking is distinct is distinct from "risky" drinking (reaching a peak BAC between .05 gm% and .08 gm%) and a "bender" (2 or more days of sustained heavy drinking).

For some individuals (e.g., older people; those taking other drugs or certain medications), the number of drinks needed to reach a binge-level BAC is lower than for the "typical adult."

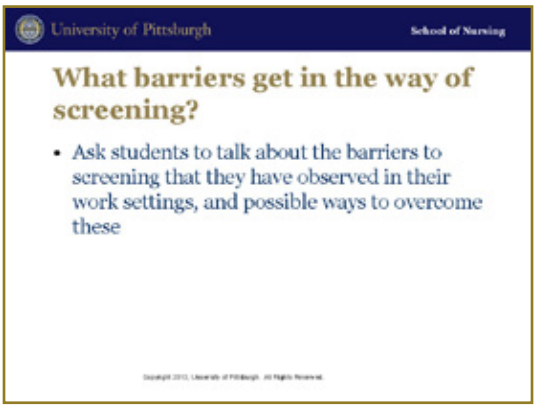
People with risk factors for the development of alcoholism have increased risk with any alcohol consumption, even that below a "risky" level.

For pregnant women, any drinking presents risk to the fetus.

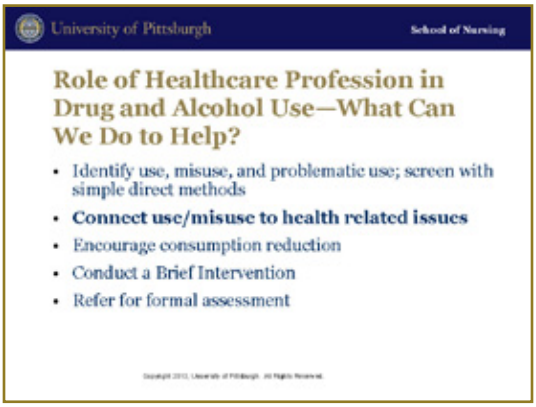
Drinking by persons under the age of 21 is illegal.




**10.** **TRAINER NOTE:**




**11.** **TRAINER NOTE:**




**12.** **TRAINER NOTE:**

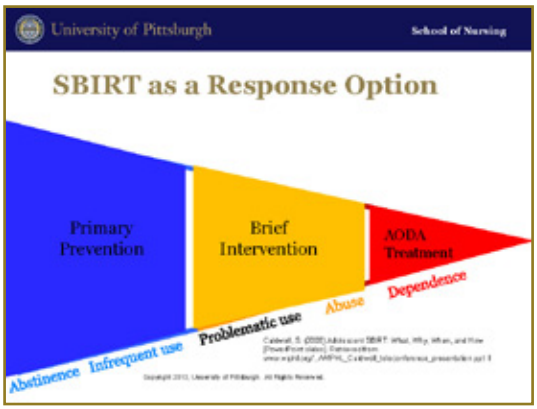
Lists the various ways that health care workers can address problem drug and alcohol use. Especially emphasize the connection between the patients' health related issues and their use of alcohol and drugs. This is the key pathway for nurses to use to bring up the subject and continue with a brief intervention and a referral for further assessment/ treatment if necessary.


## 13. TRAINER NOTE:

The primary goal of screening is to assist the health care professional in identifying harmful patient drug and alcohol use, using as little time as possible.

Screening can also help the health care professional to establish a helpful relationship with the patient.

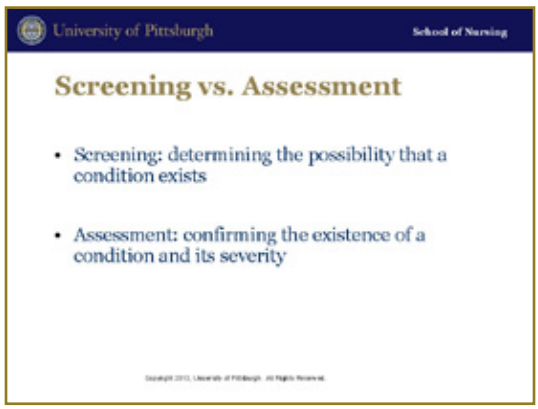
Patient's are provided information needed to make good health-related decisions.




## 14. TRAINER NOTE:

This slide shows that SBIRT is a response option across the spectrum, from abstinence to dependence. Remind students, however, that it is not the job of SBIRT to diagnose dependence. That can only be done through an assessment process beyond the scope of SBIRT.

Caldwell, S. (2008). Why SBIRT with adolescents? [PowerPoint slides]. Retrieved from www.wiphl.org/.../WIPHL_Caldwell_teleconference_presentation.ppt




## 15. TRAINER NOTE:

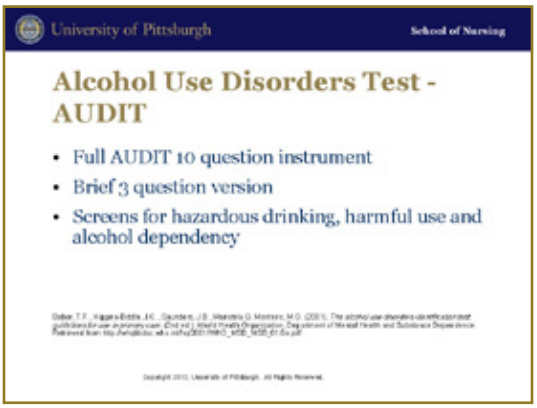
Help the students understand that the goals of screening are limited. Screening is not the same as diagnosis or even assessment. High scores on a screen should lead to further assessment that may or may not lead to a diagnosis of addiction.


## 16. TRAINER NOTE:

Pre-Screens can be used as a quick way to determine whether or not a patients should be given a more complete screen, like the AUDIT or the DAST. Both the NIAAA and NIDA have developed one question screens. If a patient reports one or more occurrences on either screen this should trigger more in-depth screening or even a brief intervention.

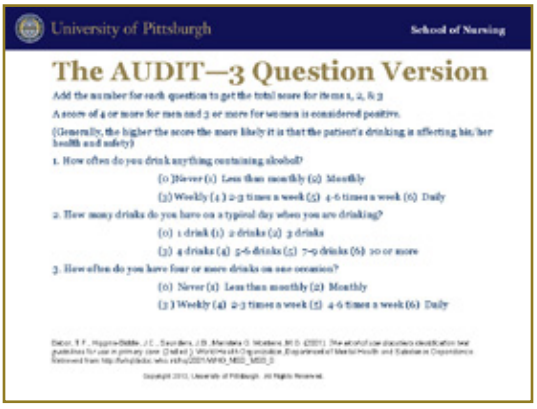
National Institute on Alcohol Abuse and Alcoholism. (2007). Helping Patients Who Drink Too Much: A Clinician's Guide (NIH Publication No. 07-3769)

National Institute on Drug Abuse. (2011). Screening for Drug Use in General Medical Settings: Quick Reference Guide (NIH Publication No. 11-7384)



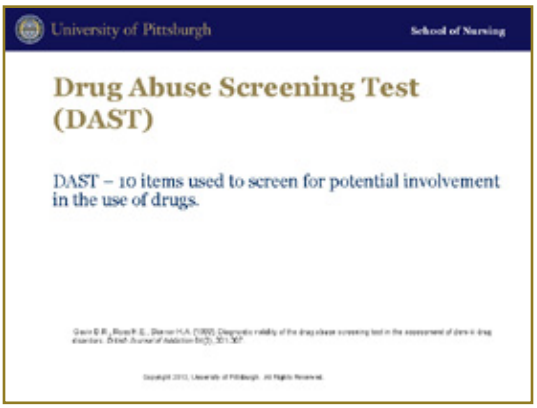

## 17. TRAINER NOTE:

Babur, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.



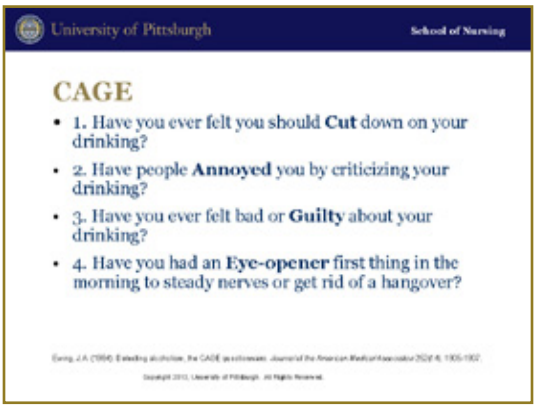

## 18. TRAINER NOTE:

Babur, T.F., Higgins-Biddle, J.C., Saunders, J.B., Maristela G. Monteiro, M.G. (2001). The alcohol use disorders identification test guidelines for use in primary care. (2nd ed.). World Health Organization, Department of Mental Health and Substance Dependence.




## 19. TRAINER NOTE:

Gavin D.R., Ross H.E., Skinner H.A. (1989). Diagnostic validity of the drug abuse screening test in the assessment of dsm-iii drug disorders. British Journal of Addiction 84(3), 301-307.




## 20. TRAINER NOTE:

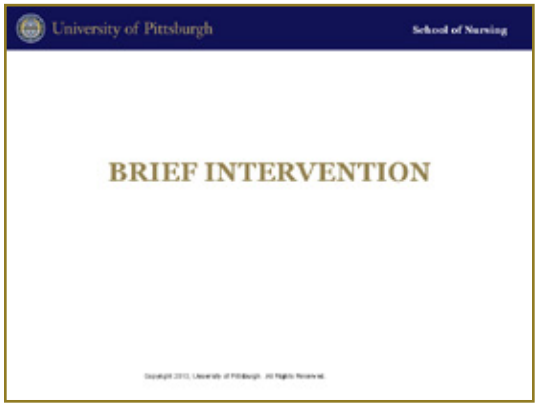
Ewing, JA. (1984). Detecting Alcoholism, the CAGE questionnaire. Journal of the American Medical Association, 252 (14), 1905-1907.

Advantages

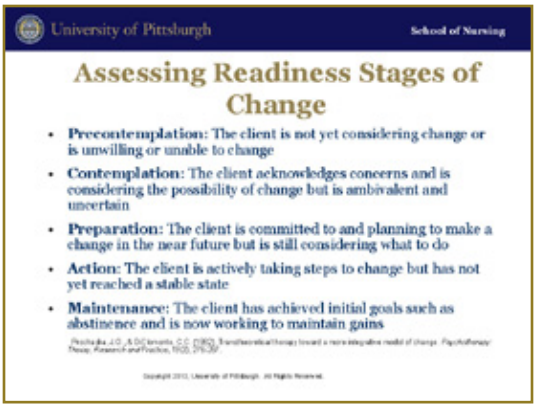
- Brief and non-confrontational
- Widely used and validated
- Sensitive and specific for alcoholism
- No training required for administration

Limitations

- Not validated for pain patients
- Shown to be less specific and accurate than other more extensive screening tools, such as the AUDIT (Magruder-Habib et al. 1993).
- Less accurate in adolescents (Knight et al. 2003), women and minority populations (Volk et al. 2007).




## 21. TRAINER NOTE:




## 22. TRAINER NOTE:

Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy toward a more integrative model of change. Psychotherapy: Theory, Research and Practice, 19(3), 276-287.

Stages of Change is a transtheoretical model of behavior change developed by John Prochaska and Carlo DiClemente to explain how individuals intentionally change.

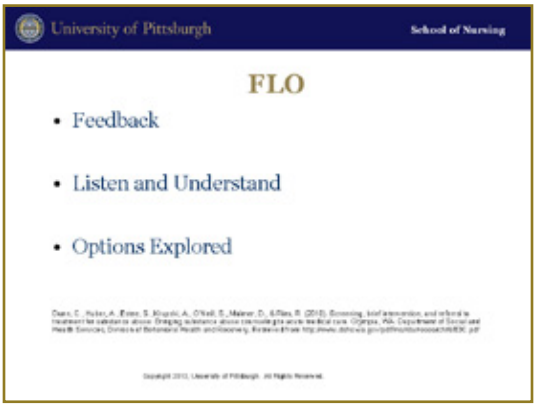
It is an evidence based model of change and has been shown to be relevant for a range of health-related behaviors.

In addition to identifying where an individual is in the change process, this model also identifies the types of activities in each stage which will help the individual to progress to the next stage.

This slide provides a description of each stage of change in the model.

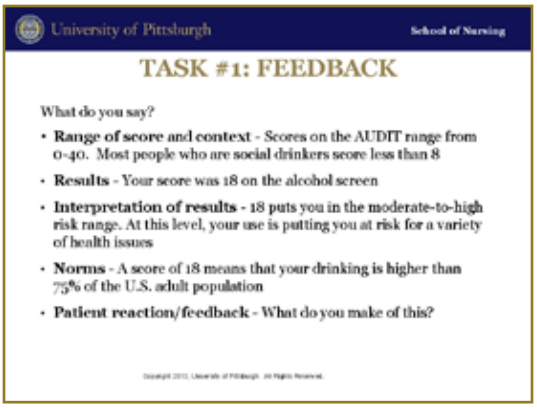

## 23. TRAINER NOTE:

Print each stage of change on a separate index card. Print the bolded statements from the CARD SORT ANSWERS sheet also on separate index cards. Break the students into small groups (3-5). Ask them to arrange the appropriate strategies of stage of change under the correct stage of change card. Get a report back from each group before sharing the correct responses.




## 24. TRAINER NOTE:

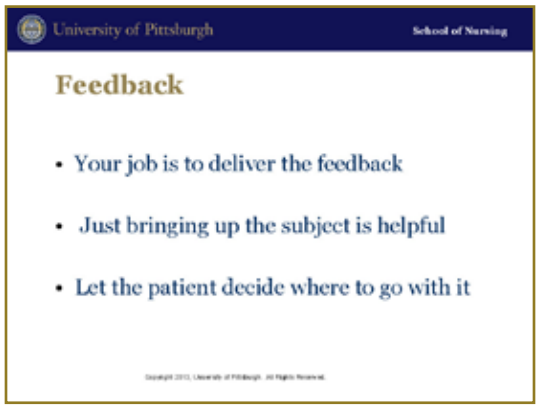
Dunn, C.W., Huber, A., Estee, S., Krupski, A., O'Neill, S., Malmer, D., & Ries, R. (2010). Screening, brief intervention, and referral to treatment for substance abuse: A training manual for acute medical settings. Olympia, WA: Department of Social and Health Services, Division of Behavioral Health and Recovery



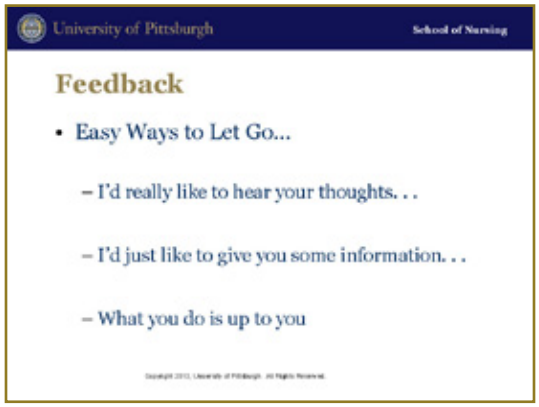

## 25. TRAINER NOTE:

Here are examples of what we say when we give feedback. We will use an AUDIT score as an example.

Read each bullet and provide an opportunity for discussion.



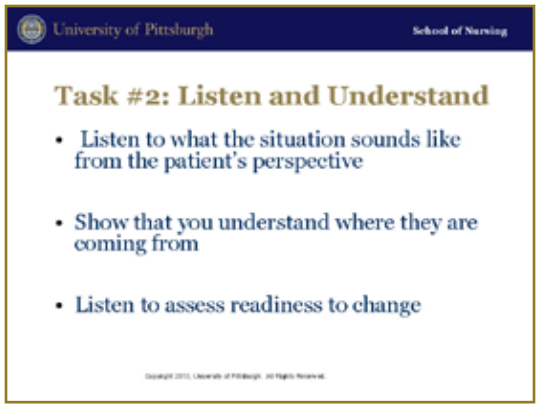

## 26. TRAINER NOTE:



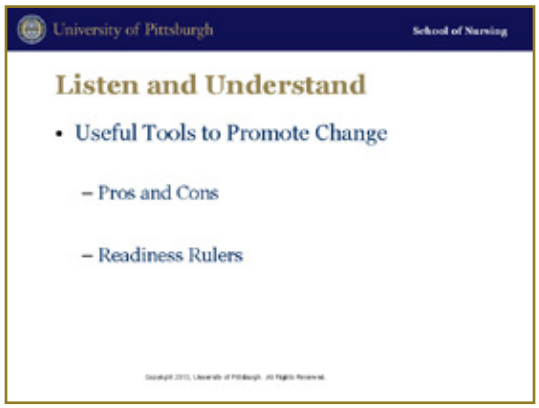

## 27. TRAINER NOTE:

How do we let go?

We can present the screening information as a means of providing the best care for our patients and let the patients decide what to do with the information. We can say, "I'd like to give you some information that concerns your health. What you do with this is entirely up to you." If you stick to the objective information at hand—the screening results—you can keep your personal judgment out of the picture.

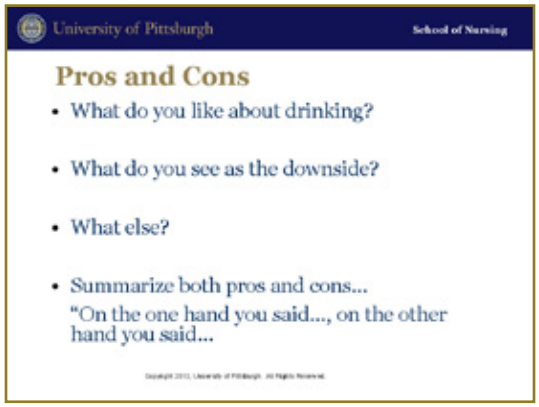



**28. TRAINER NOTE:**



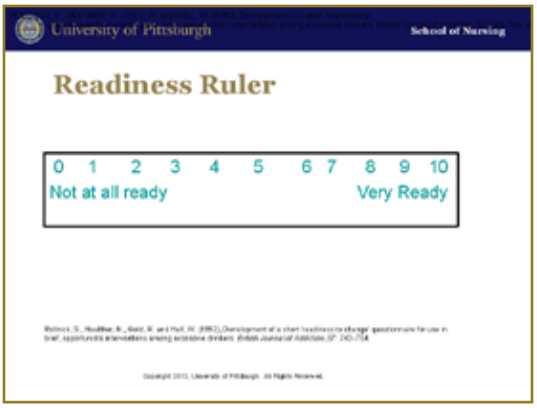

**29. TRAINER NOTE:**

We'll now look at effective tools to get the conversation going: identifying pros and cons and using a readiness ruler.



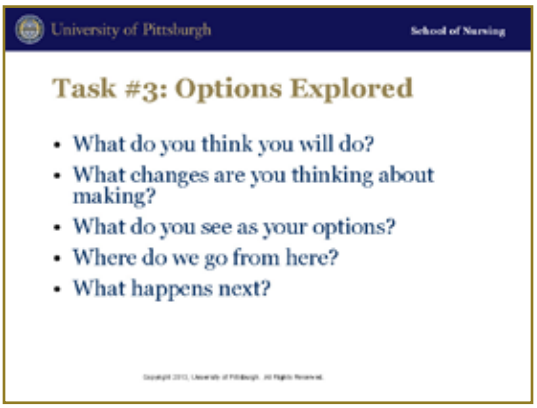

**30. TRAINER NOTE:**

We want the patient to discuss the pros and cons of using alcohol and/or drugs. This is unusual for many of us because as health providers and educators, we tend to only talk about the negative aspects of alcohol and drugs. If we can appreciate the good things about using, we can understand the underlying need of using (feeling less depressed, increased social interactions). This can help point the way to solutions once we get to that point. Discussing the positive effects of use can also help to build rapport.



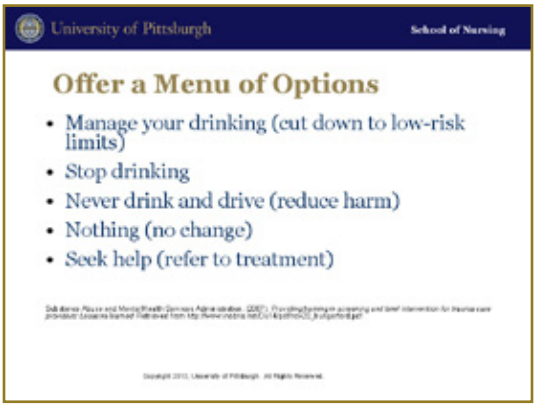

## 31. TRAINER NOTE:

Ask the patient to circle a number from 1 to 10 with 1 being not at all ready to change and 10 being very ready. When they circle a number, ask why they didn't circle a lower number, which invites them to talk about reasons to change. You can also ask "What would have to happen in order for you to circle a higher number?" This same ruler can be used to help the patient to determine how important making the change is and how confident they are that they can make the change.



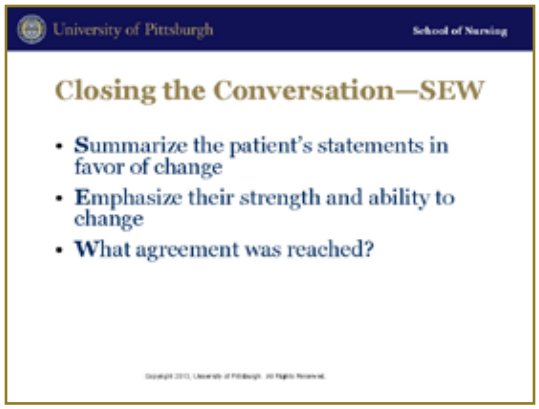

## 32. TRAINER NOTE:

Exploring options is the third task in the FLO brief intervention and this is where we talk about what happens next for our patients. We can ask questions like "What do you think you will do? What changes are you thinking about making?" With a brief intervention, the responsibility is on the patient to decide what to do. And again, what they choose to do with the information that you provide is completely up to them.



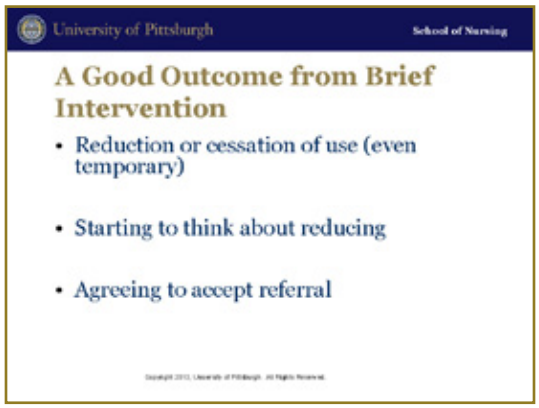

## 33. TRAINER NOTE:

Reviewing a menu of options with a patient can be a way of helping a patient move in the direction of change. It give the nurse the chance to make suggestions, sometimes concrete suggestions. The patient retains the right to choose which option they feel ready to try, including doing nothing at all. In the end, it is the patient who is responsible for deciding what they will or will not do.

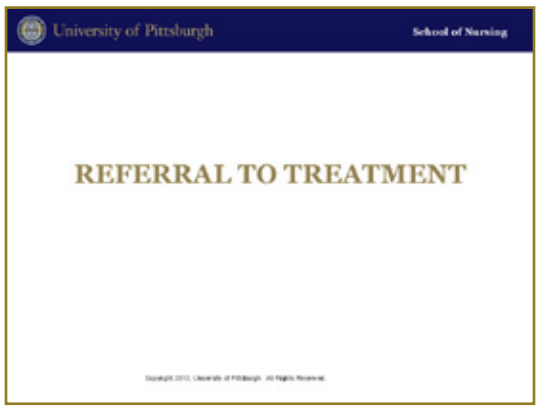



**34.** **TRAINER NOTE:**

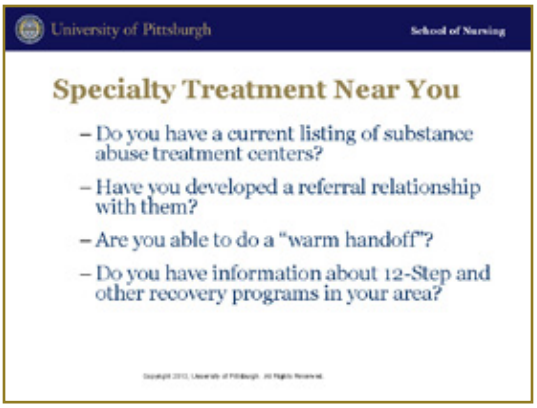
This acronym helps us to remember how to close out a brief intervention.




**35.** **TRAINER NOTE:**

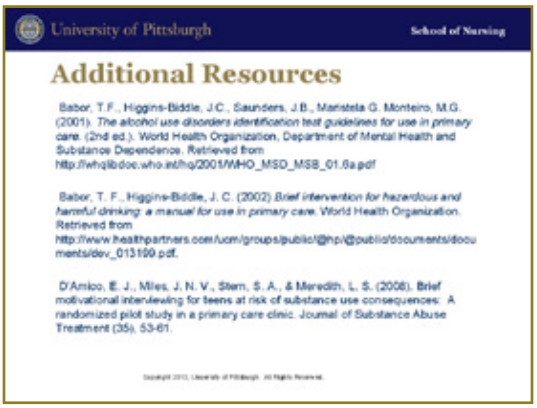



**36.** **TRAINER NOTE:**

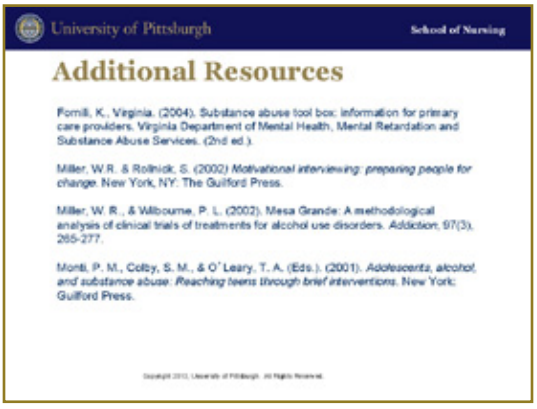



## 37. TRAINER NOTE:

The booster session ends with a discussion about referral to treatment. Students should be encouraged to be prepared to make such referrals when necessary. Good preparation will help reduce stress about having to make a referral. Patients may or may not be ready to accept a referral for further assessment or treatment. But if clear and accurate referral information is given, the patient may decide to take action on their own at a later date.




## 38. TRAINER NOTE:

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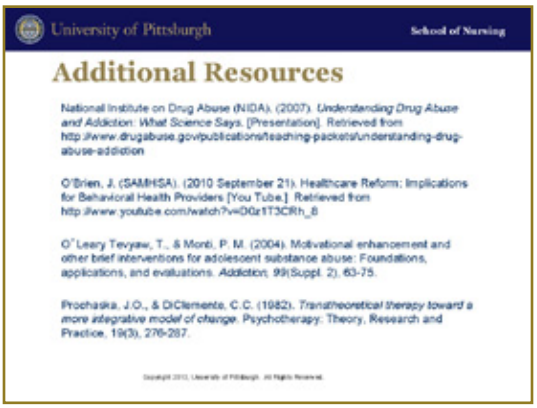


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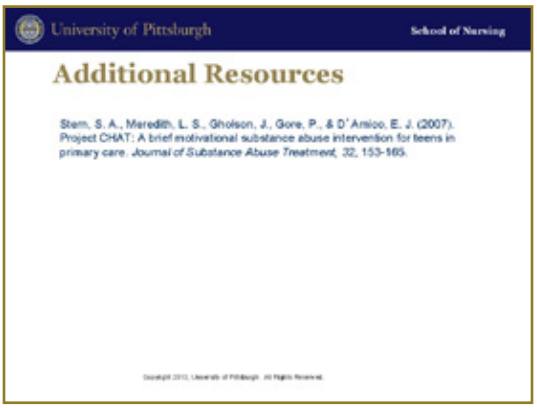


**41.** **TRAINER NOTE:**

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Education & Training
in Addictions